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ABSTRACT

The report is part of a national inquiry initiated in 1966 (One Million Children) in a cooperative effort to identify some of the problem areas of services in Canada for children with emotional and learning disorders. The report of the Ontario Committee gives a provincial focus to the wider 4 year study and reflects local implementation based on results of the national study. The stated tasks of the Ontario Committee were to assemble information about and assess existing services for emotionally disturbed children, examine projects underway in Ontario, and frame recommendations derived from these findings. Throughout the report the authors indicate that services to children have grown piecemeal, with gaps and overlapping. The importance of different levels of preventive activities is stressed as a potential bridge to the gap between services available and population need. Recommendations for the consideration of local authorities such as a community-centered approach, and local involvement and responsibility for services are also made. (CD)

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The Report of the

Ontario Committee

of the

Commission on Emotional and Learning Disorders in Children

a supplementary publication to

ONE MILLION CHILDREN

the CELDIC report

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September 1970
165 Bloor Street East Toronto 5 Canada

Copies of the Report are available through the office of the

Canadian Council on Children and Youth,
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Toronto 5, Ontario.

Preface

The report of the Ontario Committee gives a provincial focus to the wider four-year study undertaken nationally by the Commission on Emotional and Learning Disorders in Children. At the outset the sponsors of the study felt that local implementation based on results of the national study would best be ensured if a provincial group became involved in concurrent studies.

The Committee's observations and comments are therefore particularly concerned with provincial patterns of service that affect children with emotional and learning disorders. As a comprehensive investigation was not planned, the Ontario Committee members selected for study certain specific situations that appeared to them to be significant. The aim throughout the enterprise was to pave the way for increased and more effective provisions in Ontario for meeting the needs of children with emotional and learning disorders.

The multi-disciplinary approach reflected in the composition of the Committee proved to be stimulating and valuable, and resulted in a most interesting experience for those involved. Perhaps others will see such dialogue as a prototype in miniature of what is essential in each community. One consequence was that consensus was not reached on every point contained in the document; it is likely that each member working in isolation would have given a different slant to this report. Nevertheless, in spite of varying views and points of emphasis, this diverse group reached unanimous agreement on all major issues and aims.

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THE ONTARIO REPORT

THE STUDY

THE WAY IT IS

THE WAY IT OUGHT TO BE

RECOMMENDATIONS

CONTENTS

Preface i

The Committee members ii

THE STUDY vi

The task vii

The method viii

THE WAY IT IS 2

HIGHLIGHTS OF THE PROBLEM 3

CHILDREN IN TROUBLE 8

SERVICES IN TROUBLE 25

THE WAY IT OUGHT TO BE 63

THE GREATEST CHALLENGE 64

THE PRE-SCHOOL YEARS 69

THE SCHOOL YEARS 80

NEW DIRECTIONS 93

RECOMMENDATIONS 100

for the consideration of

LOCAL AUTHORITIES 104

HEALTH AUTHORITIES 107

EDUCATION AUTHORITIES 110

PROVINCIAL AUTHORITIES 116

Acknowledgements xii

THE STUDY

THE STUDY

The task

The method

THE TASK

The Ontario Committee of the Commission on Emotional and Learning Disorders in Children - CELDIC - is a part of a national inquiry initiated in 1966 and sponsored by the Canadian Association for Retarded Children, the Canadian Council on Children and Youth, the Canadian Education Association, the Canadian Mental Health Association, the Canadian Rehabilitation Council for the Disabled, the Canadian Welfare Council, and Dr. Barnardo's of London England.

This unique partnership venture arose as a tangible expression of grave concern by six national voluntary organizations with a common interest in the well-being of Canadian children. It was a cooperative effort to identify some of the difficulties currently perceived around the provision of services for children with emotional and learning disorders and to address the questions of how they could and should be overcome.

Since the national sponsors wished to invite the active participation and interest of the health, education and welfare fields in Canada, it was fitting that they should focus attention on stimulating provincial activities relevant to the study of emotional and learning disorders in children.

In Ontario a two phase project plan emerged: phase one to study services for children with emotional and learning disorders; and phase two, to concentrate on social action needed to improve standards and effect changes in present patterns of services to children in the province. Two committees were formed for dual, but somewhat overlapping purposes. One committee was composed of representatives of the Ontario Welfare Council, the Ontario Association for the Mentally Retarded, the Ontario Division of Canadian Mental Health Association, the Ontario Association for Children with Learning Disabilities, the Ontario Society for Crippled Children, The Ontario Association for Emotionally Disturbed Children, the Ontario Education Association - Special Education Section, the Ontario Committee of the Canadian Council on Children and Youth. This was known as the Advisory Committee. Their collaborative efforts were to be called upon at a later stage for the purpose of furthering the aims of the Commission locally, though in the study phase their cooperation was sought with regard to sharing information about innovative programs or new approaches to services with the study group that was formed concurrently.

A second committee - the study group - was composed of representatives of various professional disciplines and became known as the Ontario Committee of the Commission on Emotional and Learning Disorders in Children.

The Ontario Committee was convened in February 1968 on an ad hoc basis. The following objectives and tasks were agreed upon.

Objectives

To gain an appreciation of how current practices in the provision of services for children either enhance or detract from their effectiveness

To review the potential of new approaches in the provision of children's services

To submit a report to the sponsors of the study, the Ontario Advisory Committee and the community in general

Tasks

To assemble information about existing services for children with emotional and learning disorders

To examine new and innovative projects underway in Ontario

To assess and comment on the adequacy of services offered

To frame recommendations derived from these findings

THE METHOD

The Committee came to the conclusion early in its work that it must establish a frame of reference and a backdrop of basic concerns against which to gauge how services are meeting the needs of children. In order to gain a further appreciation of how current practices either enhance or detract from the effectiveness of services, it was necessary to delineate specific areas of interest so that the collection of data could be undertaken in a systematic fashion. In addition it was necessary to trace some of the main forces that have influenced the ways in which Ontario services are presently organized and operated.

Our questions were complex. How does one go about the task of fact finding when the queries are so extensive that they almost suggest that years of study must precede action? To what extent is our present network of services able to respond with timely and relevant help once an emotional or learning problem has been identified? Can services change and adapt to new conditions and at the same time provide continuity of care? Are there specific legislative and administrative barriers to the provisions of more effective

services? What programs focus attention on preventing emotional and learning disorders in children? And, last but not least - what innovations are taking place that indicate new approaches to the solutions of the problems about which we are concerned?

These questions and many more were raised in connection with services provided through various departments of government, voluntary agencies and private practitioners in the various relevant fields. There was a simultaneous interest in exploring the nature of the services for different age groups, different stages of mental and physical development, different kinds of families and different sizes and types of communities, all with their different needs. The quandary of 'where to begin' was obvious.

The study group considered several possible methods.

The inventory approach

Information gathering was included in the mandate received from the Commission. However, as a sole approach it has several built-in limitations. When compiled by agency and by department, the impression conveyed is usually one of the tidiness of what exists and of the excellence of future plans and intentions of politicians, practitioners and fund raisers. It tends to sanctify existing patterns of service. It infers that there is a comprehensive network of services which can be examined, and that if only enough statistics are collected, we can understand all the 'whys and wherefores' of what is going on. In practice, however, factual inventories neither raise nor answer the most pertinent questions and become out of date very quickly.

Further, in a province like Ontario, the sheer volume of material is prohibitive. The preparation of abstracts of reports and descriptions of programs for the whole province was not feasible in the time available. Finally, reports of this kind are extremely boring to read.

For these reasons we agreed that a comprehensive survey of the existing patterns of services for children with emotional and learning disorders was not practical. Instead we decided to examine the provision of services under the headings, health, education, welfare, law and corrections, and to undertake our study in a fairly informal manner by inviting people to share their ideas and observations wherever possible. Therefore, we held interviews and corresponded with personnel of various public and voluntary agencies that provide services for children with emotional and learning disorders.

In this way we found we were better able to interpret the objectives and operation of programs than if we had been solely dependent on written reports and descriptions of programs. This was amplified, where available, by a number of provincial reports, studies and research documents.

The single problem approach

This approach entails the selection of one area of interest, and the compilation of data on that one aspect, for all services in the province that relate to children with emotional and learning disorders. This kind of enquiry was conducted in Ontario with respect to two CELDIC studies on 'Incidence' and 'Manpower'. As we had been asked to provide provincial data in this connection, the staff was held responsible for collecting the pertinent information to be passed on to the Study Committee preparing the main national Report.

Since our mandate also called for a review of the potentials of new approaches to services, we drafted a questionnaire on innovative programs. The Advisory Committee provided an extensive list of such programs which was of considerable help in deciding on the questionnaire's appropriate distribution. The completed questionnaires were then compiled as a 'Summary of Innovative Programs for the Prevention, Remediation and Treatment of Emotional and Learning Disorders in Children' January 1969.

The field visit approach

This approach was being very profitably used by the national Study Committee in its enquiries across the country. The reports of these visits emphasized the discrepancy between many of the statements of intention that appear in annual reports and the degree to which these policies are put into effect. The Commission members also remarked upon the value of seeing innovative programs at first hand, with the opportunity to put questions to the staff who are engaged in testing and evaluating new theories and patterns of service.

Since Ontario had recently evolved a new regional plan for extending special services to children, we placed emphasis on finding out how the collaborative efforts of five provincial departments of government were progressing in the implementation of the Government of Ontario White Paper 'Services for Children with Mental & Emotional Disorders', tabled in the legislature by the Honourable Matthew B. Dymond, January 1967. Therefore, in addition to a series of enquiries

addressed to representatives of the five departments of government and others associated with the plan, representatives of the Committee made a field visit to one regional centre.

The single population approach

We chose this approach for a case study that included some aspects of each of the three methods described above. It enabled us, in a relatively short time, to compile and present material and to raise questions for discussion involving the services provided under a number of different auspices. Also it highlighted, through the population chosen, some of the omissions and inequalities in the overall pattern of services to children with emotional and learning disorders. This approach also had the advantage of beginning with the children where they lived, so that one could see, in vivid human terms, the operation of services and the result of previous omissions.

This approach led to a report on the use of commitment to training school for children for whom no appropriate community service could be found. The two part report served as a background paper for our study and included: a survey of the Ontario Training Schools population, with particular reference to the availability of service for children with emotional and learning disorders; and a survey of one group of boys in training school with particular reference to their individual experience of services for children with emotional and learning disorders.[1]

From all of these methods we have tried to extract the facts that we think need to be public knowledge. It is, admittedly, an arbitrary selection. But our comment on the 'way it is' is presented in our Report in the hope that the citizens of Ontario will find some merit in our suggestions for the 'way it ought to be.'

---

1 Moffat, Patricia White Oaks, A study of children in a training school, undertaken for the Commission on Emotional and Learning Disorders in Children

T H E W A Y I T I S

T H E W A Y I T I S

HIGHLIGHTS OF THE PROBLEM

CHILDREN IN TROUBLE

SERVICES IN TROUBLE

HIGHLIGHTS OF THE PROBLEM

HIGHLIGHTS OF THE PROBLEM

The Commission on Emotional and Learning Disorders can be seen as a natural consequence of a widespread concern about those children in our society who, for one reason or another, do not or cannot conform to our expectations of them. This concern has many forms and many diagnostic labels such as delinquency, drug abuse, rebellion, withdrawal and dropout - terms reflecting the failure of a child to develop normally as seen from the varied viewpoints of the professions of medicine, psychology, psychiatry, social work, education and law that are charged with responsibilities for children.

Some of the main forces leading to this state of affairs can be readily identified. Fifty percent of the population of Canada is under the age of twenty-five. Education has been mounting in cost, duration and numbers served, and consequently in complexity. The achievement of various educational levels became, in our society, the essential ticket for any and every employment situation. Failure to achieve was tantamount to a catastrophe in life, affecting future income and status. Special educational programs snowballed in numbers and appeared to stem the tide of adverse responses; the helping services were called to rescue the casualties and both education and the helping services became swamped by the magnitude of the problem.

The cause continued to be sought in some shortcoming of the individual: in his maladjustment, his failure to achieve, his failure to conform.

Agencies maintained their emphasis on treating casualties at the end of the line, because the involved personnel saw this as their role and because pressure was exerted by the community for institutionally based answers. With the increasing demands, the helping systems have come to an impasse and must now attempt to rearrange their forces. This will require that they redirect their attention back to the community, as the source of the problems as well as the source of the remedies.

The school systems with a progressively larger captive population for increasingly longer times and with constantly increasing goals and aspirations for their students and staff, have attempted to adjust to social demands. But increasing demands invariably carry in their wake increasing failure, since man is not infinitely pliable and learning has limits.

Faced with the complexity of factors to be considered, our Committee had to make choices and decisions to give focus to its work. We would have liked to spend more time looking

at the social matrix and the stresses that arise from it. We did not delve into admittedly pressing problems, such as the drug issue, because other bodies were already conducting intensive studies in this area.

Although the individual child in his family, school and community has remained the basis for our discussion, the primary emphasis that emerged was on the helping services, their isolation and fragmentation and how they could be brought back into the context of the community as a whole. Two fundamental parameters of problems in service provisions emerged from the many discussions, contacts and explorations with those in the business of helping others. Regularly and frequently these were identified, both as operating practices and as the origin of difficulties.

The first of these derived from the attitude to individual differences. The establishment of expected modes of behavior and performance led naturally to the labelling of those who failed to meet these modes as belonging to discrete and deviant categories. Isolated by diagnostic means, these children were then cared for by an increasingly isolated series of services, more and more removed from their social and peer community. The more severe the disturbance, the more isolated became the provision of services; from the normal class to the special class, to the special school, to the institution removed and separated from its community of reference. The major effect of these trends has been the establishment of a great range of treatment programs housed in highly identifiable buildings and therefore patently visible. It is fairly obvious that one of the greatest problems is the capital investment of funds in institutions because disproportionately large segments of available funds and of personal involvement become tied up in this real estate. In the history of the development of social services, the establishment of segregated agencies and institutions was probably a necessary stage. It was society's best known way, at the time, to care for those with special needs. But well intended and partially effective though it has been, it has had its concomitant adverse effects.

The second factor closely related to the development that led to the first was the fragmentation of services. Despite the most altruistic intentions, helping services tend to be identified with the bricks and mortar so that a structure of people becomes as formidably separated from its counterparts as the series of buildings that contain them. When this happens, the service ultimately responds less to the needs of the consumer than it does to the needs of the building and people that it houses. The series

of services under different auspices and different administrative hierarchies resembles a giant jigsaw puzzle with many key pieces missing. The pieces that are available are highly specialized and the spaces between them are obvious. Entry into the services is difficult and their utilization is perplexing and confusing, even to those who know their limitations. Further, because of the cost factor and the funding mechanism of our times, these services tend to become centralized. This organizational pattern results in the loss of community involvement, as the institution takes over and the community is held progressively less responsible for caring for its own members. Throughout this report, there will be a constant emphasis on the community concept and the need to restore the community to a position of responsibility and involvement with the services it receives.

Another contribution to the fragmentation of services was the multiplicity of available pathways to services. Depending on who first saw the child, he might be viewed from a medical-psychiatric, psychological-behavioral or psychological-educational vantage point. The agencies and institutions chosen to take responsibility for care and treatment similarly depended on this chance factor. Within these parallel streams there grew assiduously specific brands of professionals, who were competitive for funds, acceptance and significant memorials - in the form of the institutions that they helped to develop.

Different government departments were involved; different and restrictive categories for funding were established and prevailed. Adherance to their professional and institutional territories kept apart those with similar concerns, with comparable programs, and often with even the same clients. This lack of relationship of agencies to each other left glaring gaps in service, discontinuity in service provision, and fertilized the tendency, already present, for institutional isolation.

With these two factors as highlights of the problem, the committee makes the recommendation that planning be based on the following major principles:

> Isolation is to be combatted by developing relevant and innovative services that permit the child with special needs to remain in his own home or community.
>
> Fragmentation should be met by a policy of integration of existing services that will create a continuum of services available for all children, at any age, for any need, in each community.

The policy of government and other controlling bodies must be such that the organization patterns and funding mechanisms of services will express and promote the two principles above and thereby enable communities to plan, develop and administer services for children and their families.

CHILDREN IN TROUBLE

A casualty service

The training school population

The juvenile court and community services

Profile of a group of boys - White Oaks Village

Age of admission and length of stay

The implications of wardship

Children's Aid Societies, histories

Developmental histories

Learning problems

The classroom program

Tested intelligence

Contacts with community agencies and clinics

Summary

CHILDREN IN TROUBLE

A casualty service

Because we believe our services are essentially geared to 'mopping up' after the crisis is over rather than adopting preventive measures, our committee expressed interest in finding a case study that would help us to consider how existing programs actually serve children and their families. Since training schools are really the end of a long arduous journey for some children, and represent a post hoc intervention, it was felt that a retrospective examination of a group of children, in one of our correctional institutions, would help to highlight some of the inadequacies of our present service system in responding to the particular needs of all children.

Institutions have been defined as 'frozen answers to fundamental questions' [1] Although used in a different context by the author, this seems an apt definition in terms of our enquiry which is concerned with seeking alternative answers. Our fundamental questions might therefore be phrased:

> How can services be designed and utilized
>
> to combat isolation of the child from his own home or community and
>
> to create a continuum of services available for all children, at any age, for any need?

Some children may be seen as the victims of our inability to answer the latter question. Such a group may be identified in the population of Ontario Training Schools, since the training schools receive the casualties, the children whose problems have become so compounded that we resort to the 'frozen answer.'

We take no issue with the quality of care provided in Ontario Training Schools. We are concerned here with the much larger issue of how the community can respond to the child's needs before it is too late.

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1 Feibleman, J.K. 1956 - The Institutions of Society London: George Allen & Unwin Ltd. p.52

The training school population We chose the Ontario Training Schools as our study population because there is evidence that many of the children in this group are residual cases who become wards because of the absence of other community services:

Section 8 of the 1965 Ontario Training School Act reads, in part,

> 'Upon the application of any person, a judge may order in writing that a child under sixteen years of age at the time the order is made, be sent to a training school where the judge is satisfied that:
>
> (a) The parent or guardian of the child is unable to control the child or to provide for his social, emotional or educational needs;
>
> (b) The care of the child by any other agency of child welfare would be insufficient or impracticable, and
>
> (c) The child needs the training and treatment available at a training school.'

Judge William Little, in a study of four hundred and sixteen court cases over a period of a year when he was Director of Social Services, Juvenile and Family Court of Metropolitan Toronto, came to the conclusion that:

> 'Recommendations to training schools are at least a third higher than is warranted because of the lack of resources available in the Metropolitan Toronto area for children who require treatment away from their own homes but not necessarily training school setting.' 1

For our purposes, Section (a) of Section 8 might read:

> 'The parent, guardian or home community of the child is unable to control the child or to provide for his social, emotional and educational needs.'

Additional reasons for the choice of this group were as follows:

> It is a province-wide population, although the department offices and the training schools are in

---

1 Little, William, The Diagnostic Clinic in a Juvenile and Family Court Setting Metropolitan Toronto, Canada 1968 (mimeo)

the south of the province. Almost any other group that we might have chosen for a brief review could call our findings into question as applying only to Metropolitan Toronto and the urban, affluent 'Golden Horseshoe' area. But children come to the training schools from every county and district in Ontario.

Owing to the judicial nature of committal, the training schools, unlike almost any other setting, have no control over the number and kind of children that are admitted. This fact and the 'total institution' nature of the program seemed to us to provide a unique opportunity for our committee to become better acquainted with the children whom the families, schools, agencies, clinics and courts of the province have found most difficult to handle.

The Department of Correctional Services (formerly the Department of Reform Institutions) has undertaken a number of evaluative studies of its newer programs. Two of these were of particular interest. A treatment program at Galt involving the use of operant conditioning methods with one group of girls, with a control group in the regular Galt program and the program for younger boys at White Oaks Village which combines treatment in cottage-type living units with an extensive program of remedial education. A comparative study of this group is in process comparing its progress with a control group from the more traditional program at St. John's Training School. [1]

Because of its mixed population many of the problems experienced by the training schools relate directly to the community service problems that have been engaging our attention. This is particularly apparent when we examine the histories of the younger, more disturbed group of children who could not be sustained by existing remedial and treatment programs in the community and who were committed to training schools before the age of twelve.

The juvenile court and community services In addition to increasing concern about the legal rights of the child before the court, there has been growing recognition in recent years of the need for early detection and treatment of the social and emotional problems that precede and accompany delinquent behavior in children. In the context of a discussion of the role of the home, the school and the community in delinquency prevention, the Department of Justice Committee put this task in Professor Tappan's words:

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1 Grygier, Guardino, Nease & Sakowiz, Social Interaction in Small Units: New Methods of Treatment and its Evaluation in: Canadian Journal of Corrections, Vol. 10 No. 2 April 1968

'The entire gamut of juvenile problems appears in the delinquent population, yet the occurrence of any particular problem or combination of problems does not imply that an individual will become delinquent. Children who display serious maladjustments whether or not they are headed towards delinquency require help that is appropriate to their manifest difficulties rather than to their future state. Treatment then should be given as a child welfare measure generally, not as a preventive of delinquency.' 1

Where we look at services presently charged with some responsibility for the young offender, the problems of divided jurisdiction emerge very clearly. For example, the administration of the Juvenile and Family Courts is in the hands of the Attorney General's Department and the training schools come under the Department of Correctional Services. In preparing this report we discovered that the two departments use a different reporting year: The Attorney General's Department follows the calendar and Correctional Services the financial year, so that it is not possible to compare court and training school statistics directly.

We had some discussion with staff at the Toronto Juvenile and Family Court in order to learn about programs run by the court staff. We also tried to obtain some estimate of the range and accessibility of community services available to the court in relation to children whom it perceived as having emotional or learning problems. We also hoped to obtain some initial impressions about the experience that children coming before the courts have already had with services for children in the community.

The following problems were described as giving the most difficulty to court staff.

Facilities for disturbed children are scarce and expensive and the acting-out delinquent child comes low on the priority list. Because residential treatment for disturbed children is so costly, some children are made wards of Children's Aid Societies in order to admit them to these centres under public auspices. In these circumstances wardship can have the effect of giving support and legal sanction to the negative side of the parent-child relationship and this can hinder treatment.

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1 Juvenile Delinquency in Canada 1965, The Report of the Department of Justice Committee on Juvenile Delinquency, Ottawa: Queen's Printer Para.400 - 401

The majority of children coming before the courts and needing residential care are already too old, or their acting-out is too severe for them to gain admission to a residential treatment centre, because these centres give preference to children who have more supportive parents and a better prognosis and who, they feel, can gain more benefit from the services offered. It is very common for these children before the courts to have had a diagnosis of emotional disturbance and recommendations for treatment made at an earlier age, but the recommendations were not carried out and the child appeared again at adolescence with a delinquency problem.

It was estimated that most of the children coming before the court have reading problems so that failure experiences pile up at school as they get older; indeed some children come before the court because they will not go to school. Remedial reading programs are expensive and there appears to be a shortage of people trained to do this work in the public schools. There are two teachers working in the detention home and it was hoped that diagnosis of learning problems might be included in the assessment process already undertaken by the court. However, the staff has found that information from the schools is quite difficult to obtain and they claimed they had encountered communication problems with a series of principals, vice-principals, psychologists and school social workers.

The idea of Regional Diagnostic Centres projected in the Ontario Government White Paper on 'Services to Children with Mental and Emotional Disorders' is promising, but it is not clear whether the organizational framework is going to have enough thrust behind it in the way of budget allocation to increase substantially the amount of service available, or whether these centres will simply make more effective use of the facilities that exist at present. Unless the amount of service is increased considerably, the centres will do very little for young offenders who have a poor prognosis and few spokesmen in the community. The initial impression of the court staff has been that the existent treatment services will not expand much in the near future, because there is a general view that this would move the services beyond the optimal size for good clinical practice and effective teaching of staff in training.

In view of the problems outlined above, the court has developed a number of supportive and helping programs to compensate for the inaccessibility of community programs to young offenders. Some of these programs by the court staff are designed to provide a 'head start' kind of intervention, giving deprived and socially incompetent children enough beginning skills to gain admission to a community program. In providing counselling and social skills these programs

have had some success. But they have encountered severe difficulties in their attempts to address the learning problems of the young offenders because specialized consultation and personnel were not available for the severe and long standing problems that the children showed. The staff found that a tutorial program run by volunteers was simply to weak an intervention to make any impression on the learning problems of these children.

In summary then, the experience of the Toronto courts with community services would seem to support Sheridan's findings.

> 'Even in large communities where a variety of public and private agencies have been established, corrections personnel have generally had little success in securing services; rigid intake policies and already established waiting lists have effectively screened out the delinquent and his family and established agencies have been extremely reluctant to accept referrals from police or courts, particularly when these involve troublesome and rebellious adolescents.' 1

When we asked the court staff about a typical sequence of events leading to a court appearance, the reply was that the child was usually deprived of stability and affection in his family in his early years so that he entered school with some kind of maturational lag. This made it difficult for him to achieve a basic reading skill so that he encountered increasing failure and discouragement in the classroom. In school his problem was either overlooked, if he sat quietly at the back of the class, or recommended treatment was not carried out. Or, if carried out, it was, by then, not effective enough to make much of an impact on the accumulation of insecurity, anger and discouragement. As a result of this sequence of events the child's anger would break through at a later age in the form of delinquent behavior. Or, a crisis in family relationship or school attendance would bring the child to the attention of the court.

Staff at the court argued strongly for early detection and intervention for these 'high risk' children so that their parents could be supported and helped to grow in their capacity to respond to the child's emotional and developmental needs. They spoke of programs such as the one at Duke of York School in Toronto which provides a range of services and experiences for children beyond the regular public school

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1 Sheridan, William H. Juveniles who Commit Noncriminal Acts, Why treat in a Correctional System? in: Federal Probation Vol. XXXI No. 1 March 1967

hours. The court saw a need for more social workers or other helpers who would visit in the home as the public health nurses do, to identify with the problem in the parent's terms. When we asked how many of the children now coming to court fit this general description, the reply was, 'a good 85% had they been diagnosed and treated early, would never have come to court at all.' There is no research data which substantiates this statement, but it is the expressed opinion of an experienced worker.

The findings of this preliminary survey of one population group seemed to support our initial impression that community services for children with emotional and learning disorders are mobilized on a crisis basis and at a very late stage. Although problems are often identified early, community resources and programs are seldom available to respond with appropriate help to the child and his family while it is still possible to sustain the child in his own environment. The children coming before the court present complex and interrelated problems and have a history of lost opportunities so far as remedial intervention is concerned.

Profile of a group of boys - White Oaks Village

The following summary of data relates to the fifty boys who were resident in the Ontario Training School Program at White Oaks Village on the 19th of November, 1968. Our sample group represents all the non-Catholic boys in the province committed under the age of twelve. The White Oaks program is geared to the needs of this group, which is generally much more disturbed and handicapped than the training school population as a whole. The Village with its dual emphasis on therapeutic group home living and remedial education yielded records which coincided closely with the interests of our Committee and our enquiry was further enhanced and made enjoyable by the interest of the staff in the questions that we were exploring.

Age of admission and length of stay The average age of admission for our group was ten years and three months with a range from eight years, five months, to eleven years, eleven months. The average length of stay at the Village, measured in November 1968, was sixteen months, ranging from a group of boys who were transferred to the program when it opened in January 1966 to some newcomers who had been in residence for less than six months. At the time of our survey, the average age of the boys in residence was eleven years, five months, which reflects the fact that this younger group seems to require a longer period in residence than the training school population as a whole. Provincial figures show that most wards return home to their families or to foster home placements in less than a year. 1

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1 The Ontario Plan in Corrections Report of the Minister of Reform Institutions, 1967

In recent months this program has encountered some difficulty in planning for a group of boys who have been in the program for more than two years but who cannot be discharged because no appropriate educational or other needed facilities are available for them in the community. In view of this placement problem the school has now set up a group program geared to the needs of the adolescents for whom no community facility could be found. The staff remarked that the boys appear to reach a plateau after two years and that those who remain in the institution for a longer period tend to deteriorate in their learning and social development. There are some older boys who have been at White Oaks Village since it opened. They have made considerable strides but there is a danger that they will lose the ground they have gained unless appropriate placement and special educational help are available to them in the community.

The implications of wardship When a child is committed to White Oaks Village he remains a ward of the training school until he reaches the age of eighteen. This does not mean that he remains in residence for that length of time, but it does give the Department substantial powers as the Training Schools Act names the superintendent of the school as the guardian of the child. However, his parental function can only be exercised in a highly general way. The several powers and limitations of this delegated responsibility have rarely, to our knowledge, been tested by the courts.

When the time comes for the child to return to his home community, the superintendent is required to exercise guardianship even though the child might live hundreds of miles from the training school. We are deeply concerned about the effect of this situation upon the child and his parents, because this prolonged and ambiguous system of guardianship does not necessarily guarantee either effective legal protection or a close personal relationship for the child. The danger, in our view is that the child will be well cared for but homeless; he does not really belong to anyone.

As a committee we regret that we are unable to offer a possible solution or alternative suggestions for the present guardianship system, but we do wish to draw attention to this matter as one that requires further study.

Children's Aid Societies, histories In our examination of the sample group of fifty boys resident in White Oaks Village, we found that twenty-five had been known to Children's Aid Societies and eleven had spent time in wardship care. A survey conducted by the Ontario Association of Children's Aid

Societies in June of 1968 identified three hundred and ninety emotionally disturbed children under twelve in the care of Children's Aid Societies in the province, for whom no appropriate facilities were available. [1] The boys in White Oaks Village are distinguished from this larger group by the fact that their emotional disturbance was expressed in a manner that constituted a danger to themselves or to others so that the more structured setting of a training school was thought to be necessary. The boys were committed to training school because they were running away, or fire setting, or they were in need of a residential treatment setting which was not available at the time.

From the CAS histories of twenty-five boys it appears that the intervention of the Society is usually mobilized a little earlier than the training school committal. But the largest part of CAS activity that we have been able to trace has been in response to the emergency of child neglect in the case of younger children, and to the general disturbance and anxiety created by acting-out behavior in older children. Even in the longer term cases there was little indication that the Societies had the funds or the staff to give the support that they would have wished to families who were having difficulty in raising their children. A number of Societies expressed regret about the lack of adequate funds to help high-risk children and their families at a stage when it might be possible to sustain them in the community. In this connection several comments were made by CAS correspondents about the lack of a range of helping services and the formality of many of those that are in operation. One writer emphasized that home visits are often seen by parents as an expression of willingness to reach out to a child and his family. However, many treatment programs insist on carrying out their work in an office setting which produces a quite different reaction in those being served.

In summary then, the contacts that the boys in the sample have had with Children's Aid Societies would seem to indicate that they are the physically uncontrollable minority of a much larger group of disturbed children uncovered by the CAS Association Survey. These are children for whom there is very little treatment available, although there appears to be a general availability of diagnostic assessment by appropriate specialists. This sample also illustrates the use of CAS wardship to fund or safeguard a period of residential treatment. In two of the eleven cases, wardship was obtained in recognition of the child's need for this kind of care, and in a third case, wardship was used to provide some structure and controls in a treatment situation involving children and family relationships. Of the twenty-five boys who had contact with the CAS, eleven had spent a period in wardship care and between them had had a total of

1 Children without Appropriate Facilities Survey by the Ontario Association of Children's Aid Societies June 1968

nineteen admissions to care.

Developmental histories The staff at White Oaks had compiled developmental histories for most of the boys by having the mother of each boy complete a form which included the medical history, details of the child's emotional development and the behavior problems that he showed at various stages of his life before admission to training school. None of this material is exhaustive because it is based on recollection, but it does serve to show the range of identifiable difficulties that were present in these children very early in their lives.

Difficulties encountered by the mothers during pregnancy covered a variety of problems, including miscarriage, kidney infections, toxaemia, depression and family problems. Birth difficulties were also mentioned and pertained to premature birth, breech birth and jaundice of the infant at birth.

Developmental problems and symptoms that were observed by the mother when the boy was young, ranged in nature from the most common garden variety of complaints e.g. feeding problems, to the extremes of beating and other abusive treatment by parents. Sexual assaults upon the child, firesetting, stealing and truancy were included in this fairly extensive list. Parental separations were mentioned frequently.

Health problems, hospitalizations and illnesses in early childhood also covered a gamut of difficulties including head injuries, heart murmurs, hearing problems and emotional problems.

Since very few of the families of this group of boys had a private physician, the medical records consist mainly of notes from visits to the emergency department of the local hospital. The picture that emerges from these records repeats the pattern that we observed in our examination of the boys' experience of all services - a lack of continuity of help even when symptoms are discerned. It points up the missed opportunity for much needed intervention and follow-up before a crisis occurs. The consequences of lack of help, or help provided 'too little , too late' are clearly evident in the case histories of this sample group of young boys committed to training school.

Learning problems A second large sub-group at White Oaks consists of children with severe reading and/or speech problems. The Speech and Reading Clinic at Brantford General Hospital offers remedial reading and speech therapy help to these children.

Of the fifty boys in the sample, twenty-five were identified as having reading and speech problems requiring remedial help, fifteen have a dyslexia, five have other reading problems, twelve have a dyslalia and five have other speech difficulties. In the course of these assessments the Clinic identified twelve boys who were not able to read at a grade one level. The distribution of these boys by area of origin is approximately the same as that of the sample group as a whole, i.e. with eight coming from urban areas, two from smaller centres and two from northern areas. The distribution of the whole sample group by county and district of origin approximates the population of the province; thirty-three boys came from urban areas, ten from non-urban regions in Southern Ontario, and seven from Northern areas.

A closer examination of the school records of the twelve boys who could not read, shows that their classroom teachers identified them as having learning problems, or as immature or disruptive children within their first two years of school. The interaction of emotional and learning difficulties is most striking in the school histories of this group of boys, and the evident frustration of the child and his teacher in the face of his inability to read grows more apparent each year. The school records of this group serve to illustrate the cumulative effect of illiteracy on the behavior and functioning of the student, and on the capacity of the school to require and sustain his continued attendance and interest.

The classroom program From conversation with the principal and staff and from reading the records, the following general picture emerges of the classroom situation at the Village.

The White Oaks boys generally have very negative, depressed or angry feelings about school and these feelings are bound up with their experience of authority and their poor self-image. Some of the boys come to the Village after a period under suspension or on home instruction and it is not unusual to find a boy who has missed several months of school. It takes about four to six months for a boy to complete his initial testing behavior in the classroom and to gain enough incentive to begin to learn.

The initial task is to help the boy gain enough emotional stability to begin learning at his own level, whatever that

may be. After this process of learning has begun there is an uneven rate of progress in view of the difficulty that the boys have in functioning consistently within a structured situation. For the more volatile students a program is worked out between the teaching staff and the house staff to make certain that emotional upsets are handled in the same manner. The boy can withdraw to a study area or the library, or he may return to the house if the teacher feels that the classroom situation is too much for him to handle. Child care staff are sometimes used in the classroom if it is felt that this will help a child to sustain himself in the learning situation for longer periods. The goal is to prepare the boys for the regular school situation on graduation and two of the White Oaks boys are presently attending a public school in the community in anticipation of their graduation.

In the group of boys at White Oaks there are about seven who are totally illiterate and another twelve or so who are functionally illiterate, i.e. reading at a grade one level or below. About 80% of the boys in the program have reading problems. Because many of these problems are emotionally based or are compounded by an emotional problem, joint conferences take place to look at the child's behavior and progress, and to plan ahead on the basis of shared observation and assessment and the material available from outside sources.

Tested intelligence Wisc intelligence test results were available for all but two of the sample group and they showed a mean full scale rating of IQ 93 with a range from 66 to 120. The group of twelve boys that we have described with severe reading problems have a mean IQ of 91 with a range from 77 to 105. Four of this group have a discrepancy between verbal and performance scores of twenty points, so that the full scale rating would tend to be misleading.

Contacts with community agencies and clinics We began our review of this group of boys and their contacts with community services by giving some account of school and child welfare programs. Because these two agencies tend to see the largest number of children, their programs have great potential for the early identification of emotional and learning disorders in children. As we have already implied however, activity at the present time tends to be initiated in response to a crisis situation, particularly when this involves either running away, or physically destructive behavior. In passing we have tried to illustrate, with the help of the mothers and classroom teachers of the boys, how the children who later showed this alarming behavior were presenting evidence of their emotional and learning problems before the age of six

and generally long before they were old enough to attend school.

It is possible to look in detail at the nature and extent of the range of physical, neurological and emotional problems as they are carefully documented in the White Oaks records. However, as the overwhelming majority of these revealing assessments were done after the boys were admitted to the program, their presentation at this time would be misleading, in view of the Committee's primary interest in the availability and functioning of community services for children who are not in institutions.

In the contacts that the boys in our sample had had with clinics, hospitals and social agencies before they were admitted to White Oaks Village, we can observe a pattern of intervention similar to the one we saw in relation to their contacts with the Children's Aid Societies. In both cases most of the activity took place within a year of the child's committal to training school and coincided with his period of acting-out behavior and school difficulties. This observation confirms our initial impression about the limitations of the referral system in relation to early detection of disorders, even when that service is located within the school system itself. We have included in Table I, a list of these contacts.

The Child Adjustment Service of Toronto Board of Education was included in this analysis in the situations where it had functioned as a parent counselling and referral service in a way that was comparable with the service offered by family agencies and mental health clinics. Therefore, we did not include Child Adjustment Service records that related to the placement of the child within the school system, but did include records directly concerned with obtaining clinical service and/or offering management help to the parents of the disturbed boy. The youth counselling service worked with one boy and his parents at the request of the court and provided service that also resembled the mental health clinic approach. We did not include counselling by probation officers and other court workers, nor did we include psychiatric assessments that were prepared for the guidance of the court. The probation officer contacts were numerous enough that they might obscure our immediate concern with clinical service in the community, and assessment facilities offered by the courts are not treatment services in any sense of the word.

Our summary of contacts made with community clinics, hospitals and agencies concerned with emotional problems reveals that from our sample of fifty boys, twenty-nine were involved in a total of forty-one contacts of this kind. Of the remainder,

TABLE I CLINICAL SERVICE CONTACTS

made for boys*

in White Oaks Village prior to committal

Types of Contacts	No's of Contacts
Reviews of applications for in-patient and residential care	12
Assessment and referral only	10
Assessment and medication	5
Management help to parents by Clinic	2
Parent counselling by Child Adjustment Services	5
Counselling of child and parents by youth agency	1
Play therapy	1
Emergency in-patient care	1
In-patient treatment	1
Residential treatment centre	2
Other residential care	1
Total number of contacts	41

* Number of children in sample group - 50. Number of children involved with clinical services - 29.

twenty had no record of this kind and one had incomplete information in this area. Twenty-two of the forty-one contacts involved intake and assessment services, with twelve of them being concerned specifically with an application for in-patient or residential care. Of the remaining nineteen cases, five received medication only, eight received management help or parent counselling, one received counselling of the child and his parents, one play therapy, and the remaining four in-patient or residential care. Of these four cases, one involved placement in a private boarding school, one in an in-patient unit and two in residential treatment centres.

Summary In a general review of the extensive records of this province-wide group of fifty boys, we have tried to raise and illustrate some of the more pressing and complex problems in the provision of service in Ontario and elsewhere to children with emotional and learning disorders. None of our analyses has indicated that any particular variation within the group related either to region of origin or to age of admission. A similar range and combination of problems seems to be present in the boys at White Oaks, whether they come from urban areas, small towns or northern areas and we would be tempted to speculate that the selection factor resides in the multi-problem nature of the children's emotional and learning difficulties.

Our findings may be summarized as follows. A retrospective look at the early childhood development of the boys in this sample suggested the need for a screening service in the pre-school years in order to identify high-risk children, for example, those whose development suggests the presence of organic or neurological problems. We have the impression that children from low income families receive very little ongoing medical care in the years one to five. The public health nurse is strategically placed to provide the kind of service we have in mind.

In the course of this enquiry we have learned a little about the assessment and treatment of specific learning and speech disorders and how they relate to one another and to emotional problems. The delay in identification of these problems seems to compound any social or emotional difficulties that the child is having. Also the lack of an adequate number of remedial reading specialists in the community presents a serious placement problem for boys graduating from the White Oaks program. The implications of such a shortage in terms of the need for early remedial intervention are also serious.

The Children's Aid Societies of this province are charged with a general responsibility for children who are neglected or

whose families are having difficulty in raising them. We have the impression from a review of the White Oaks records and from a brief survey report by the Ontario Association of Children's Aid Societies that a substantial number of emotionally disturbed children are presently in CAS care, but they lack the alarming visibility that characterizes the stress behavior of the training school group. We are also deeply concerned about the effect of the present CAS and training school guardianship systems as they relate to these disturbed and demanding children. Our community does not seem to have the tested experience or the appropriate resources to provide an adequate 'home base' for disturbed children whose capacity to relate within a family is impaired.[1]

Finally we have explored the extent and nature of the contacts that our sample group had with community clinics, hospitals and agencies which are set up to provide service for children with emotional problems. The findings from this survey resemble the CAS picture, in that intervention comes at a late stage and in the case of clinical services is concentrated in the areas of assessment and diagnosis, without an equivalent development of ongoing treatment services.

1 Rae-Grant, Quentin and Patricia Moffat, Issues in Residential Care a study undertaken for the Commission on Emotional and Learning Disorders in Children

SERVICES IN TROUBLE

A network of services

How communities are meeting the needs of children
An innovative approach to coordination of services
The school in relation to other community resources
A community-centred approach
A program based on the community school concept
A school volunteer program
Marital and family counselling services
Financial support of family service agencies
New approaches to provision of family services
The value of early intervention
The role of Children's Aid Societies
Funding difficulties
A quasi-public child welfare service
Public health programs of prevention
Early detection of emotional and learning disorders
Health supervision in the formative years
Services provided in child health conferences

Efforts at systematic planning

Social and family services
Health services
New legislation

Day care treatment programs
Correctional services
Educational services
Educational liaison role
Education in residential treatment centres
The courts
Diagnostic and treatment facilities in the juvenile courts

Probation services
Regional committees

SERVICES IN TROUBLE

A network of services

We often hear people speak of a 'network of services', in referring to social welfare programs. Kahn claims that:

> '... a network is a system involving case integration and if you mesh the pieces they touch the individual. A network involves policy co-ordination that has all the parts and some sensible relationships among them in terms of what they are trying to do... a network even involves machinery - How do we get into it? How do we get out of it? Who sorts you out? Who decides where you belong? Therefore, it involves some community agreement on hierarchy relationships - Where do you go first? Who develops the resources? Who evaluates? And who listens to whom? A network also involves the concept of accountability...that is somebody has to worry as to how the product is turning out and how it is moving along. We don't have a network. The use of the word network is rhetoric rather than fact. But it is a useful idealistic idea if you want to reform the system. You look at what you have, and you look at the gaps and the shopping for service, and the lack of data integration, and you say how would we be if we really were a network...how would we reform the organization?' [1]

As a committee then we looked at 'the gaps, and the shopping for services and the lack of data integration', and we asked 'how would we be if we really were a network...how would we reform the organization?' And in our crystal gazing we directed our view to the community as the source of the problems as well as the source of the remedies.

Our survey took different forms. We attempted to get a broad picture of how communities view services for children with different needs, how programs are organized, how the referral system operates, and how different agencies see their roles. We held interviews with people who were involved in setting up new programs, or who had researched a specific topic, or who had a wide background of experience in the field, and were willing to share their knowledge with us.

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1 Dr. Alfred Kahn in his address to the Troubled Child Conference, Toronto November 5 - 8, 1968

We approached and met with staff members from a variety of community agencies, departments of government and school boards. Our inquiries were set up in an informal manner to obtain information about community resources for services to children and families. We did not design a research tool for gathering data. Instead, we corresponded and spoke to people wherever possible, always welcoming their comments about present patterns of services, and the ways in which they envisaged change.

It was our intention to examine the barriers that seem to stand in the way of achieving an effective service to children in need, so that we might direct attention to alternative ways of helping children and their families. We therefore elected to report only some of the information gleaned from our survey of provincial services, in an effort to highlight specific problem areas. We have also projected some new ideas and trends in programs through illustration, because, although it is premature to evaluate these programs, our impressions are positive, and we think diversity in attempts to respond to children's needs should be encouraged.

Briefly stated, our enquiries found gaps in information and statistical data available, similarities in attitudes projected by agency personnel, and ambiguity in legislative and funding provisions for the care and treatment of children with emotional and learning disorders.

The section that follows is a combination of specific comments received from agencies and institutions, and general conclusions reached through committee deliberations. Manifestations of the problems of current service patterns - isolation, institutionalization, fragmentation, centralism and professionalism - are both implicit and explicit in the material selected.

How communities are meeting the needs of children When contacting the staff of social planning councils and family service agencies in Ontario for comment on programs relevant to our study, we indicated our interest in the broad spectrum of services ranging from day care programs for young children to mental health clinics and in-patient treatment in hospitals. We also stated that we were interested in programs that might be termed 'preventive', e.g. pre-natal care, marital counselling, early detection and 'head start' activities. We asked for a very general commentary on how the respective communities are meeting the needs of children with emotional and learning disorders. We then went on to say, 'we welcome your view of problems of existing systems of services; gaps in services; the barriers to meeting the different and special needs of children; community attitudes

as they affect the development of such services, etc.'

The responses to our queries contained many similar general themes, although some respondents chose to provide more details about programs and services than others. By referring to a survey of services conducted in his community one of the respondents gave us an accurate picture of the community's needs and resources. This submission provided us with an excellent illustration of how the adverse factors we delineated at the outset, influence service patterns. We therefore elected to include some of its content verbatim as follows:

> '...When in 1965 a critical situation was reached (clinic No. 1 had established a three month waiting list, clinic No. 2 a four month waiting period and clinic No. 3 was unable to accept any referrals) a United Community Service survey was made as an attempt to determine the incidence of emotional and learning disorders as reflected by clinics, family and children's agencies, the courts and special services of the Board of Education. The outcome of the survey was to arrive at an estimated incidence of emotional and learning disorders in 10% of children five to sixteen years. The estimated number receiving help was 1.5%...This in a city considered to be in a fortunate position with regard to the potential for staff recruitment and training.'

Our respondent then summarized the finding of the report.

> 'Agencies have indicated that in order to obtain services for children and their families they have to 'shop' for services by enquiring in turn at each of the resources.
>
> No one person is responsible for deciding whether or not a referral is appropriate.
>
> Policies for the care and treatment of the emotionally disturbed child are not applied throughout the community.
>
> There is a lack of systematic accountability by services and their staff to the local community and to the province. When the responsibility is divided, no one is able to report on the precise dimensions of the need, or even to establish the machinery to collect the necessary statistics. No one is responsible

for ensuring the adequacy or effectiveness of existing services.

There exists an inability to deploy the total staff available in the most effective way. Because of the autonomous nature of agencies, it is not possible to offset staff shortages in one clinic with staff from the others. Neither is it possible to determine the appropriate responsibilities of the out-patient services in relation to other community agencies.'

While emphasing that there have been some positive changes in individual agencies since the findings of the report had been known, he claimed that still

'Much the same community situation remains as indicated in the quotes from the report. Services tend to be developed unilaterally within the framework of the agency's autonomy. These services are soon used to capacity, frequently overtaxed. Sometimes they collapse. More frequently they are enlarged, with the total time absorbed by requests that are within the orbit of service that the agency has accepted. Where the child's need requires connection with or continuity by other agencies, the breakdown in service occurs. None of the 'parties' seems able to solve the breakdown dilemma, nor give it much of a priority as an unmet need. We have also observed that where there is an effort to design such services, it is typically in the areas where the answers are easiest to come by; adding professional personnel, securing government financing, providing accommodation and the like. The more difficult questions of how to achieve co-ordinated or integrated service for children among the variety of services available, is frequently left in limbo.'

The above describes so well some of the current problems encountered in communities across Ontario, that further comment on our part would be superfluous. However, we do wish to stress that our respondent emphasized that the city to which he made reference was considered to be in a fortunate position with regard to its potential for staff recruitment and training.

An innovative approach to co-ordination of services Because of the phrasing of its enquiries the Committee became aware of a number of new and exciting attempts to co-ordinate

services at the local and regional levels. These are receiving more and more attention as people are becoming increasingly aware of the need for innovative approaches to the delivery of services. One such program radiates out of a northern provincial psychiatric hospital opened in 1968 in South Porcupine, to serve as a regional facility.

> Since no psychiatric services had existed before, it was possible to design and introduce a comprehensive mental health program offering services to children and adults, both within the hospital and the local communities.
>
> One interesting feature of the total program has been the establishment of a community mental health council in each of the six major towns in the catchment area. The councils are made up of representatives of the schools, social agencies, public health nurses, clergy, and others interested in the mental health field. These organized groups meet monthly with a visiting consultant psychiatrist to discuss policy and the management of problem cases. They are being encouraged to become involved in questions of policy and planning, and it is hoped they will eventually become the major decision-making force in the development of their respective mental health programs.
>
> The hospital also has an agreement with district boards of education to provide an appropriate number of teachers, on a rotation basis, for the continuation of the education of children in treatment in the hospital. There are mutual advantages to the arrangement as it is anticipated that personnel engaged in the hospital education program, will return to the school system with an improved capacity to deal with psychological problems.

Another community program of interest is based in a suburb of Metropolitan Toronto.

> Scarborough, Ontario, is an escalating suburb of Metropolitan Toronto with an estimated 1970 population of approximately 300,000. In Scarborough, a group of citizens and professionals established the Scarborough Mental Health Council in mid-1968 to aid in the development of accessible, relevant, co-ordinated, community-based programs for the reduction of mental health casualties, and the support of community mental health.

The Council is a community-wide effort, with an elected Executive Board and a Professional Advisory Committee. It serves to help mobilize collective community action in understanding and coping with problems of all age groups. The Council has helped develop a Community Volunteer Program, a Public Education Program, a Public Speaker's Bureau, a Community Resource Information Centre, a Distress Centre, and Community Service Centre Inter-Agency projects.

The key community agencies (Children's Aid, Family Service, Public Health, General Hospital, Mental Health Services, Addiction Research Foundation, Board of Education) have been gradually developing co-ordinated multi-service 'community team' programs in each of Scarborough's three designated 'community service areas', and also in some specific high-risk areas. Associated in these projects have been volunteers, citizen groups, clergy, physicians and other community resources such as Scarborough College, the Public Library, Welfare Department, YMCA, and Recreation and Parks Department. These innovative projects have required a re-evaluation of the pre-existing roles and capacities of the various participating services in order to relinquish or modify community-irrelevant services. The aim is to develop more effective unilateral, collateral and collaborative programs, a process which is still ongoing and frequently changing to adapt to ever-changing community needs.

In view of the magnitude of the task, community efforts to stem the onrushing torrent of casualties are still in their infancy at the present time. However, in terms of tertiary prevention, there has been a dramatic reduction in the incidence of adolescents and adults requiring psychiatric institutional care, and Children's Aid Society wards requiring long term residential care. This is attributed to the two uniquely co-ordinated General Hospital Crisis Centres whose immediately-available, relevant and supportive consultative and treatment services (including brief hospitalization when appropriate) have enabled the front line community services to feel supported, and develop an extensive repertoire of viable community resources.

The majority of community professionals have recognized deficiencies in their professional training (e.g. influences which reinforced

'professionalism', labelling, isolationism, etc.) which had inadequately prepared them for more relevant, humanistic, integrative community service. Many recognized also the pathologies in their agency, hospital or institutional systems which tended to perpetuate 'agency-need-oriented' proliferating service empires rather than co-ordinated community-identified service programs.

The Community Council has also realized that for primary prevention to occur, as well as for the development of a community wide spectrum of unduplicated services meeting gaps in need, the Council must inevitably be given greater responsibility in the data collection, planning and implementation of ongoing and future community multi-service programs. The Council has also been most pleased with the support given it by provincial government departments.

Some members of our Ontario Committee wish particular emphasis to be placed on the two foregoing examples of community programs because they represent an attack on the inadequacies of the present service system. In their opinion it is almost completely useless to pour money into additional facilities and staff, as long as present organizational patterns remain intact. They strongly urge that any effort to increase funds for programs for children with emotional and learning disorders be preceded by consideration of the basic problems reiterated throughout this document, and that solutions be sought in the development of a community-based design of services.

The school in relation to other community resources When this study was initiated, there were one thousand, three hundred and fifty-eight school boards in Ontario. On January 1, 1970 new divisional boards were established thereby diminishing the total number to two hundred and thirty-five divisional boards of education in the province.

The problems with regard to addressing specific queries to one thousand, three hundred and fifty-eight school boards led to the following necessary strategies.

We addressed questionnaires on innovations to school boards whenever we heard about a new program or new approach being carried out in a school.

We addressed the following questions to four selected school boards in urban, rural, northern and southern parts of the province.

Please state number of children in elementary and secondary public schools, English separate schools and bilingual separate schools in the area served.

Please list numbers and types of special classes for children with emotional and learning disorders.

What are the qualifications of special education teachers?

What community agencies and programs can the school call upon to assist children with emotional and learning problems, e.g. mental health clinics, family service agencies, youth and recreation programs, etc.

Please specify the number of children referred to each of these resources in a given school year.

We did not anticipate that responses to these questions would yield sufficient information to give us a valid sample of local school board policies in regard to children with emotional and learning disorders. We were interested however, in how schools related to other community agencies, and whether or not they could readily draw on the local resources available. From this standpoint the information received was of great interest to the committee.

Most responses indicated that referrals were made to a child psychiatric unit in the local community or region. The number of children referred in a given year was not always stated. One respondent from a school board that serves a school population of 60,000 and has its own educational assessment centre and auxiliary education department, stated that:

> 'The Special Education Division does not refer pupils directly to mental health clinics. The parents are often advised to discuss the possibility of such referrals with the family doctor.'

He further commented that:

> 'All services tend to be involved with large numbers of referrals and the waiting lists tend to be lengthy.'

Another respondent from a smaller city in Ontario stated

> 'The local Department of Health and Children's Aid Society assist children with emotional and learning problems. It is probable that more

co-ordination between these two agencies would help. Approximately five youngsters have been referred to these agencies during the past year.' (Enrolment in the two schools operated by this school board is four hundred and eighty students.)

A respondent in the North commented

'Indian children comprise about 80% of the pupils in this area. Those Indian children who have emotional and learning problems are the responsibility of the Indian Health Services, a branch of the Federal Government. Non-Indian children may be referred to the Ontario Hospital in.....'

A respondent working out of a northern regional office of the Ontario Department of Education supplied us with the following list of resources that the schools in that area can call upon.

Psychological unit - Education Resource Centre
Family Doctor
Alcoholic and Drug Addiction Centre
Child Care Centre
Children's Aid Society
Crippled Children's Society
Public Health Nursing Service
General Hospital - psychiatric unit

He went on to say

'As the pupils are referred to and from these resources, it is difficult to specify any number.'

The respondents generally seemed to interpret our question in regard to the availability of community resources from their own particular vantage point. We think it is evident, however, that the school and community services have rarely worked closely together, particularly if one examines developments within some of the urban school boards. Many of the larger school systems have developed their own assessment and diagnostic programs and have employed consultative staff in order to ensure the development of special programs required by children with emotional and learning disorders. These services were originally instituted to take care of pedagogic considerations within the school system, either because appropriate community resources were not available, or could not be mobilized to meet the needs of the school.

However, in setting up an assessment and diagnostic service within the school, there has been a tendency to duplicate the kind of services that are available in communities, and to

follow similar practices in labelling and segregating certain children. An additional problem is that where these services are available within the schools they have appeared to make communication with outside services less necessary, and consequently have further isolated the school and the child from access to the helping resources of the community.

A community-centred approach From the vantage point of both agencies and of school systems, a more closely integrated and community oriented system seems needed. A community centred approach permits a wide variety of service arrangements, provided these enable all the available relevant community resources to be mobilized on behalf of children with emotional and learning disorders. It calls for ongoing alliances and sharing of tasks by staff in the schools, treatment centres and other appropriate community agencies. It requires that personnel of such public and voluntary agencies as Family and Child Services, Children's Aid, Public Health Services, the school and citizen groups form a community team to facilitate co-ordination of services. If such an alliance were worked out in administrative and funding terms, it would provide greater continuity of care to the child and his family, and help those who work with the child to plan around his total needs. We therefore urge citizens to give due consideration to the formation of an appropriate and representative community team for the purpose of planning and co-ordinating services to children and families in each community.

A program based on the community-school concept In line with our emphasis on the importance of viewing the school as part of the whole community rather than as an autonomous institution, we were interested to learn of a program that has pioneered the concept that the school belongs to the community. Some of the details of the program are outlined.

> Flemington Road School in Metropolitan Toronto serves Lawrence Heights, one of the largest housing developments in Canada. It is unusual in that one hundred per cent of the school population comes from subsidized housing. For some families there is a major struggle for survival, due to low income, debts and other cumulative family problems.
>
> The social services project of the school has pioneered the community-school philosophy, based on the belief that the school belongs to the community so that its resources cannot be denied to the community it serves. The principle has been applied in some interesting ways.

Teachers are exposed to the community's style of living through home visits, through a variety of resource persons and community workers, and through participation in the community centre activities. It is a way of helping teachers to understand the environment and value systems of their pupils.

A curriculum committee, representing all educational levels, has been formed on a volunteer basis, to plan a curriculum that reflects the particular needs of the community. Real-life experience is used as the key to the mysteries of reading, mathematics, science and social studies.

Emphasis is placed upon developing the fullest use of the school's physical facilities by both individuals and a variety of outside community groups. Consequently, the school hours have been extended considerably for a variety of activities for different age groups. During the first year of operations, 70% of the students took part in programs which included gymnasium, crafts, choir, ballet, science, judo, discussion periods, etc. Leadership is provided by both volunteers and staff from participating community organizations, including the school.

The adult program took root much more slowly, but it really got underway, when informal 'get acquainted' centres were developed by the Lawrence Heights social services. Gradually interest groups have grown up in response to ideas presented by local residents. A Rod and Gun Club and Neighborhood Association now meet regularly. Dramatic groups, and other interest groups now abound. A 'family night' has been enhanced by the provision of babysitting services.

Small interest groups have also been established for teenagers. Projects have emerged in which senior secondary school students have become community service workers. In addition, a job improvement corps has been established to help drop-outs get jobs while they are taking educational up-grading courses and employment training.

The school houses a number of services that benefit the whole community. For example, the social services staff represent the supportive services within the school and provide a liaison with the home and social welfare agencies within the community.

Other professional consultants contribute to an inter-disciplinary team approach to family and children's problems through the collaborative efforts of the school personnel and an integrated service unit provided for the community by the Children's Aid Society and the Family Service Association. Over a period of time this 'school and community service team' have given attention, in their joint staff meetings and program planning, to the particular problems of a socially isolated low income community that contains a high proportion of single parent families. One indication of the support given by this collaborative program to the families in Lawrence Heights is a lowered admission to children to wardship care by the CAS.

The community-school has also shared its experiences and facilities with a number of educational and training programs operated by agencies and by other schools. Seneca College of Applied Arts and Technology uses the program as a year-long field placement for students from its social welfare course. In addition to providing a valuable learning experience for the students, this alliance strengthens the program itself because the skills and interests of each student are carefully matched either with a needed program or with a community problem that requires further exploration and research. The community-school also provides workshops and seminars for teachers and for students in social work and public health nursing courses.

A school volunteer program Another way in which the community can relate to the school is through the use of volunteers. We were extremely interested to learn that school volunteer programs are developing in a number of places in Ontario, and becoming a permanent service of the school systems where such programs were initiated.

The Ottawa Public School Board established a volunteer program in its schools as a pilot project in 1963. It has now gained acceptance as a permanent service of the school.

The selection and preliminary training of volunteers for the program is undertaken by a school psychologist and the volunteers meet regularly as a group thereafter for seminars and case study sessions. After her initial training, the volunteer is assigned to a school

where she carries out a program designed by the principal and classroom teacher to provide additional support and help to selected students. The volunteer visits the school to which she is assigned and takes the child out of the regular class for periods ranging from one half hour to half a day.

Most of the children assigned to the volunteers have behavior and learning problems that make a full day in the classroom too much for them to handle without a breakdown in concentration. The volunteer must win the child's confidence and try to restore his optimism and self-respect, while assisting him with the school work that is giving him trouble. This carefully planned and implemented program enables a number of children with emotional and learning problems to remain in a regular class by providing the teacher and the child with extra support and help.*

Marital and family counselling services Although we have elected to discuss the provision of marital and family counselling services in this section of the report, we hasten to explain that it is seen as only one of many services that are vitally important to the goal of maintaining the child with special needs in his own home. A comprehensive list of social welfare services and programs that can be supportive to parents and children for extended periods, or in crisis situations, would include day care, day treatment service, homemaker services, adequate welfare allowances and decent housing conditions. The committee does not feel there is value in establishing priorities that would suggest that any one of these services or programs is more important than another. Rather we recommend that priority be given to the provision of a range of interlocking services that enable the child with special needs to be sustained in his own home.

In exploring the availability of marriage and family counselling services in the province, we examined a brief submitted by the Ontario Welfare Council on 'Marriage Guidance and Conciliation Procedures' for the consideration of the Family Law Project of the Ontario Law Reform Commission, March 1967.

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* The School Volunteer Canadian Mental Health Association 1970

About counselling on marital problems the brief states

> 'People seek help with marital problems from doctors, lawyers, clergymen, juvenile and family courts, family service agencies and other voluntary community agencies and from professional people in private practice - psychiatrists, psychologists, and social workers. Many of these also offer pre-marital counselling.'

The report goes on to say that generally speaking doctors, lawyers and clergymen refer more serious problems requiring long-term marriage guidance to family agencies, where available, or to private practitioners - psychiatrists, psychologists or social workers.

The brief claims that family service agencies are the major organized voluntary resource for people needing help with marital problems and that marriage counselling is now a core service of their agencies.

It goes on to say

> 'There are twenty-four family service agencies in Ontario located in sixteen cities, some of them under the auspices of Children's Aid Societies. Almost all are in the southern part of the province, thus there are large areas where these services are not available.'

It notes that under the Child Welfare Act of 1965, it is possible for Children's Aid Societies to offer a preventive family counselling service and several societies have moved into this area of work.

But it predicts

> 'No significant expansion under Children's Aid Society auspices can be anticipated, since traditionally the societies were organized for the purpose of protecting neglected and dependent children and generally they see this as their primary purpose.'

This comment corresponds somewhat with the responses our committee received from personnel of Children's Aid Societies when we queried how actively they were involved in the area of preventive family counselling services. We quote from one such letter.

> '...children who need immediate protection from hazardous family situations are placed into

protective custody and into a foster home set-up, before we can attempt any form of parental counselling. In the case of the severely mal-adjusted child or the child who is emotionally disturbed to the point where a foster home would merely tend to aggravate the deprived condition, the child no doubt is apprehended, but then immediate steps are taken to refer him to an institution particularly suited to cater to his individual needs and abnormalities.

Normally, however, we are more actively involved in 'child care' and 'protection' work which consists in counselling the child after the foster home placement is made, and during the tenure of his wardship, and also counselling the parents, with the possible return of the child to his natural home.'

Financial support of family service agencies Since this report of the Ontario Welfare Council indicates that family service agencies are the major organized voluntary resource for people needing help with marital problems, it was of interest to us to learn that these agencies are almost totally dependent for financial support on voluntary funds allocated by united community chests. Furthermore, there are no formal procedures set down for purchase of service by juvenile and family courts from qualified family agencies, although the courts in particular tend to refer those who they consider require long-term counselling, to these agencies.

Of the many proposals made by respondents to the questionnaire circulated by the Ontario Welfare Council, one was submitted most consistently by all types of organizations.

'Family agencies urgently need to expand, not only marriage counselling services, but also their preventive work, pre-marriage counselling and family life education.'

The report further states that many respondents felt that government funds should be made available to family agencies for all these programs.

Since the report was published, the Ontario Department of Social and Family Services has established a Family Services Branch, with units in a few of its regional offices. This is a pilot project to explore the needs and develop appropriate services for recipients of family benefits.

New approaches to provision of family services Despite the financial instability that often deters family service agencies from planning any major program expansion, some interesting approaches to provision of service have been conceived and implemented in many areas. A staff member from the Family Service Association of Metropolitan Toronto told us of the following programs.

> '...While much of our marriage counselling is provided to couples through the casework method, a second method used in an increasing way is through marriage counselling groups. In many instances these two methods are used interchangeably.
>
> Family therapy is becoming a major approach in this agency in the treatment of family relationship problems. Many children with families are being helped in this way.
>
> Volunteers are becoming an important part of service and are making a real contribution to family life. A few volunteers at this time are visiting certain families under the supervision of the social worker who has responsibility for the service given to the family. We consider this as a way of deepening the quality of our service, as the volunteer can supplement other services given. She can give regular support to the tired, distraught mother through her friendly visiting and caring. This also can help to strengthen the mother's relationship with her children.'

The value of early intervention It would seem to us that the usefulness of early intervention has been clearly established, and whether we look at the provision of preventive programs solely in human terms or pin a price tag on them - the answer is still the same. But the difficulty of establishing or expanding preventive programs can probably be traced to the trends that we have identified. It is possible to rally help mainly in situations of acute need, and the service resources are geared chiefly to provision of help at the end of the line. Present funding patterns tend to perpetuate this state of affairs, even though it is generally recognized that it is equally important to direct efforts and funds toward the maintenance of mental health. Our concern is specifically focussed here on family situations that place a child in a particularly vulnerable position. Services supportive to families during emotional and physical health crises could do much to hold families together and prevent the tragic emotional repercussions of family breakdown.

The role of Children's Aid Societies In line with the emphasis we have placed on the need for programs to help children and their families before problems become acute or chronic, we examined the role of Children's Aid Societies in respect to programs of prevention.

The foreword of the 1968 Annual Report of the Children's Aid Society of Metropolitan Toronto, contains the following.

> '1969 marks the third anniversary of the implementation of Ontario's Child Welfare Act of 1965, which increased our responsibilities and provided new methods of financing through assumption of operating costs by the Metropolitan and Provincial Governments. These changed conditions greatly increased our opportunities for care and protection of the neglected and abused children, and enabled the societies for the first time to concentrate on measures to prevent conditions which cause neglect.'

In a further description of the work of the society this statement appeared.

> 'While protection of children from physical or emotional abuse remains our primary objective, it is now realized that social and economic benefits are greatest where equal emphasis is placed in the area of prevention, making it possible for the distressed or handicapped family to be rehabilitated to the point where children can remain within the family circle. It is toward this area-prevention that the work of the society is moving.'

Funding difficulties Despite the intentions and philosophy reflected in the remarks quoted above, CAS budgets cannot always be stretched sufficiently to place 'equal emphasis' in the area of prevention. The major portion of available funds is usually absorbed in fulfilling the statutory responsibility for care and protection of children in the province. This was evident in 1969 when cuts in provincial funding allocations to Children's Aid Societies were felt most keenly in the area of prevention, since programs for the care of wards cannot be cut back so easily.

Most Societies report too that they have an increasing number of emotionally disturbed children among their wards who presently must be cared for in treatment institutions simply because no alternative service is available. Costs in these institutions tend to be high, with the result that a tremen-

dous and totally disproportionate amount of the Societies' budgets are being absorbed by what they consider to be a 'health' rather than a 'welfare' cost. No less than 21% of the Metro Toronto CAS budget in 1968 had to be allocated to this form of service.

In its 1968 survey, the Association of Children's Aid Societies asked member agencies to indicate how many emotionally disturbed children they had in their care for whom there were no appropriate facilities. Fifty of the fifty-one societies replied to the survey and nine reported they had no disturbed children. Of the forty-one societies who reported disturbed children there was a total of eight hundred and sixteen wards for whom they had no appropriate facilities. Three hundred and twenty-eight of this total were described as severely disturbed and four hundred and eighty-eight as less severely disturbed. Three hundred and ninety of the disturbed children reported were under twelve years of age, and four hundred and twenty-six were over twelve. Thirty-three societies reported that they had had their children diagnosed by appropriate specialists and forty-three societies reported that such services were available to them.

In view of the foregoing, we wish to draw further attention to the inadequacy of the support that is available for children in high-risk situations, and stress the importance of providing services to children in their own homes, as a preventive measure. Early family centred intervention would in the long run prove to be more efficient and beneficial to the child and his family, since the gap in provision of these services can lead to the necessity for long-term care for emotionally disturbed children.

A quasi-public child welfare service Children's Aid Societies have major statutory responsibilities delegated to them for the care and protection of children in the province by the Ontario Department of Social and Family Services. However, there are many complex problems around the present provisions of a quasi-public child welfare service, because in effect the community does not have sufficient leeway to establish its own priorities. Although a department of government delegates its total responsibility to a voluntary agency, provincial funding patterns really dictate priorities, and these essentially favor the provision of substitute family care in situations of neglect, over services to strengthen and hold families together. In addition, this assignment of statutory responsibility has created some confusion as to which agency, CAS or Department of Social and Family Services, may be held accountable for these tax supported services.

This raises the question of how one defines a voluntary agency. It is true that CAS has a local board of directors who do indeed volunteer their services. The CAS Board, however, cannot exercise any control in the areas of budget or policy because the major portion of available funds is provided by a provincial government department and policy tends to be determined by budgetary considerations. Despite the inherent organizational and funding difficulties, Children's Aid Societies are to be commended for having increased activities and broadened the scope of their services in recent years.

Since we envisage a community-based design of personal care services in the future, we can only conjecture that the confusion around the assignment of 'responsibility' and 'accountability' for child welfare services will ultimately be resolved within a community framework of planning. If a rational plan is developed for the delivery of services, it will require the key agencies, including Children's Aid Societies, to be 'accountable' to a citizen's council, or other body established by the community to perform a 'watch-dog' function. Further, it would ensure that the community would, at all times, be in a position to interpret community needs accurately, to establish its own priorities and to develop relevant services. This tacitly suggests that policy for child welfare services would have to be established in the course of planning and setting policy for a range of integrated community services for children.

We recommend that recognition be given to the problems inherent in the present structure, organization and funding of Children's Aid Societies in relation to their assigned statutory responsibility for care and protection of children in the province, and that appropriate action be taken to ensure the provision of services that place emphasis on early family intervention and other preventive measures.

Public health programs of prevention In our correspondence with Medical Officers of Health, we expressed interest in community health programs of prevention, such as pre-natal care and early-detection of emotional and learning disorders in children.

One respondent from a metropolitan area informed us of inter-agency conferences that are called when necessary.

> '...when there is a complex situation where it is difficult to determine the basic problem, we have arranged an Inter-agency Conference to determine the plan of action and what worker is best equipped to handle the situation. The members of the core

committee of the Inter-agency Conference are from the Children's Aid Society, Family Service Association and the Department of Health. Key people, such as representatives from the Department of Education, family physician and workers from other health and social agencies are invited to attend.

In relation to the special classes within the school, the Public Health nurse works closely with the teacher concerned, sharing information regarding the home situation. The attitudes and relationships within the home, that influence the behaviour of the child in the school, are presented through the Public Health nurse to the school teachers, guidance people and any others that are concerned.'

Another Medical Officer of Health told us of a generalized public health program, and a continuous preventive program not only applied to the infant whether in the pre-natal period or during the first year of life, but beyond that, during the pre-school age. He further informed us of a pilot program.

'In the school age, we have had a pilot program extending over several years whereby it has been possible to find incipient cases of emotional disturbance by simple but effective screening methods.'

About prevention he had this to say.

'As stated previously my main interest is in prevention and while I recognize the preventive value of good treatment services, I am in complete agreement that the problem cannot be resolved by treatment alone. Therefore, we will intensify our preventive program designed to make some contribution to more stable marriage by and through our contacts with those young teenagers who shortly will be parents, and beyond, in the family situation.'

Early detection of emotional and learning disorders From another Medical Officer of Health we learned of a program of early detection and experimental measures in relation to children with emotional and learning disorders.

The Wellington-Dufferin-Guelph Health Unit in association with the Centre for Educational

Disabilities at the University of Guelph is developing a dual program of early detection and experimental measures in relation to children with learning disorders.

Samples of young children are being studied in the following ways: at the fourth birthday parents are interviewed by Public Health nurses to obtain systematic developmental histories including information about the child's past behavior; on school entry the parents are invited to attend group interviews in order to report any symptoms of anxiety that they have observed in the child; teachers are asked to complete a one-minute assessment form about each child in the sample and, where indicated, the children are assessed in more detail using the Bristol Social Adjustment Scale.

For some children in the sample an experimental program of preventive therapy will be initiated. This will include guidance to parents about the management of their children with particular emphasis on their emotional and learning disorders. At the same time a research team will work with the teachers and the psychological services to discover new ways of helping the child.

Follow-up studies over a period of two years are planned to evaluate the effects of the intervention of the research team.

Health supervision in the formative years Since our Committee felt that further recognition should be given to the importance of health supervision during the formative years, we turned our attention to the availability of child health supervision provided by Public Health Units in the province. The Report of Maternal and Child Health Services in Ontario prepared for the National Maternal and Child Health Conference, Ottawa, March 1967, provided us with some relevant information.

'The official health agencies in Ontario comprising 41 health units and 13 municipal health departments with full-time staff, provide child health conference services. The conferences are located in local schools, town halls, church basements, recreation centres, hospitals and health department quarters, and are held weekly, or once or twice a month. In addition, the thirteen Red Cross outpost hospitals

give a similar type of service. The child health conference service given consists of:

> health counselling alone,
> immunization only,
> or health counselling and immunization.

The clinics are staffed by physicians from the Health Department or local physicians are employed. When clinics are located in centres where medical schools are established, the resident physician at the hospital may also assist. The clinics are staffed by public health nurses who take part in the counselling, as well as graduate nurses. Volunteers - often married nurses who are living in the community - assist with the clerical work, the weighing of infants, supervision of play areas, etc. In some areas a dental hygienist is present, and in very few areas a psychologist also takes part in the child health conference services.

> The demand for this type of service has diminished over the past few years, thus in some parts of the province over 43% of children attend child health centres, whereas in others only 5% of the population attend such a clinic.'

Services provided in child health conferences The Report of Maternal and Child Health Services further informs that

> 'Physical examinations are made on the first visit to any Child Health Clinic where a physician is in attendance. Routine examinations are repeated one year later, but any child is examined when the need arises.
>
> At child health clinics and conferences a health inspection is carried out by the public health nurse, and at each attendance the nurse and mother discuss any problems which have arisen.
>
> No universal screening program is in operation across the province, although inspection for strabismus and screening for hearing defects are routine procedure in many areas.'

Among the priorities listed in the Report were

> 'The availability of child health supervision for the great majority of children in Ontario.

> Increasing recognition of the importance of health supervision during the formative years.
>
> The setting of priorities according to vulnerability of the child and needs of the area.
>
> Improving relationship and co-ordination of services with other individuals and agencies providing child care in the community.'

Among the problems listed were

> 'Lack of information regarding the value of child health conferences as they are presently constituted.
>
> Lack of a province-wide measles immunization program.'

These conclusions were of interest to our committee because we believe child health conferences could provide excellent opportunities for early identification and detection of emotional and learning disorders in children, as well as continuity of health care for large numbers of children in the province who may not have ready access to the services of a private physician.

We recommend that Public Health authorities examine the values of child health conferences as presently constituted with a view to setting priorities according to the needs of each area, implementing new programs as appropriate and co-ordinating these services with that of other agencies providing child care in the community.

Efforts at systematic planning

We were extremely interested in the ways in which the White Paper on Services for Children with Mental and Emotional Disorders, tabled in the legislature by the Hon. Matthew B. Dymond, Minister of Health, January 1967, was being implemented. The objectives inspired hope for a collaborative effort on behalf of children by the Departments of Health, Education, Social and Family Services, Attorney General and Correctional Services. It also called for maximum involvement of professional and voluntary agencies, and gave further promise of a co-ordinated effort.

> 'Representatives of each department will be identified with regional centres. Liaison personnel representing the schools, welfare agencies, public health agencies and courts will be seconded to the centre to provide an ongoing follow-up service and to assist in carrying out the prescribed treatment program.'

In our attempts to find out how the plan is being implemented, and what progress had been made to date, we corresponded with representatives of the five departments of government concerned, arranged an interview with the Executive Director of the Mental Health Division of the Ontario Department of Health, and made a field visit to one Regional Centre.

As the responses we received from government personnel helped us better to envisage the respective roles of the departments involved in the implementation of the White Paper, excerpts from these replies will be used in this section to focus attention on specific areas of interest.

Social and family services The response from the Deputy Minister of Social and Family Services seemed to lend support to our initial assumption that health was leading the way in this collaborative effort. We quote from his letter.

> 'The province through this department has made available generous capital and maintenance subsidies together with other benefits. The Ontario White Paper, which you mention, was a signal of re-doubled effort in the public sector and a recognition that the treatment of mental and emotional disorders in children is chiefly a health problem.
>
> The implementation of the plan set out in the paper is, therefore, largely under the administration of the Department of Health.
>
> The primary concern of my department, as expressed in the legislation, is to support private organizations which operate centres of care for these children.
>
> The treatment centres are being evaluated and accredited by the Department of Health and public facilities are being extended under their auspices.'

Health services The last paragraph quoted above raised many questions about 'accreditation' and 'standard setting' in residential treatment centres. In an attempt to get the answers to some of these questions, we obtained a copy of 'Standards for Accreditation of Facilities for the Care and Treatment of Children with Mental and Emotional Disorders' along with a Manual of Inspection published by the Ontario Department of Health. Upon further enquiry we learned that an accreditation process had been initiated, and we assumed facilities would be accredited under the proposed Bill 138, an Act Respecting Facilities for Children suffering from

Mental and Emotional Disorders.

New legislation Bill 138 had its third reading on December 17, 1969, and authorizes the establishment and operation of Children's Mental Centres by the Department of Health. A mental health centre is interpreted as 'premises, facilities and services provided for children suffering from mental or emotional disorders'. A Director has been appointed to the newly created Children's Services Branch of the Mental Health Division of the Department of Health, and will have the authority to issue licences to facilities under the terms and subject to conditions specified in the regulations under the Act. The Act also makes provision for a licencing Board of Review to be established.

We laud the move to establish standards of care and take the necessary steps for maintenance of standards in Children's Mental Health Centres. We were also pleased to learn that the 'premises, facilities and services' referred to in the Act may encompass a variety of treatment programs. Another item of interest is contained in Section 2 of the Act.

> '(2) Where the provisions of any Act except the Mental Health Act, 1967 and the regulations thereunder, conflict with this Act or the regulations, the provisions of this Act and the regulations prevail, and any provision in any other Act requiring or authorizing the licencing or registration of a children's mental health centre in any other capacity does not apply.'

The exception noted above is related to the recent accreditation of some Children's Mental Health Centres under the provisions of the Mental Health Act. Broadly interpreted however, Bill 138 makes provision for all children's treatment centres in the province that fit the description of 'children's mental health centres' as classified in the Act and its regulations, to automatically undergo a licencing process and be required to meet the standards of the regulations for licencing in order to continue in operation. In addition, substantial financial support is proposed to rectify some of the current difficulties around provision of residential treatment for children who require it.

At the present time the welfare stream is the main artery through which funds flow for treatment in children's residential treatment centres. The source of financing for child welfare wards in these treatment programs is through the provisions of the 1965 Child Welfare Act on a purchase of service basis. On the whole no funds have been available

through other official channels so that children could be admitted to residential treatment centres without the necessity of court procedures.

The fragmentation of services which we identified as one of the factors adversely affecting present patterns of service is clearly evident in both the public and private facilities receiving provincial funding. Different government departments are involved; different and restrictive categories for funding have prevailed. Consequently there is seldom an effective liaison and inter-relationship between the institution and other services in the community, and the institution tends to become more and more isolated from the community from which it receives its referrals. Moreover, its residents isolated from their own community, also forfeit participation in the life of the community in which they are residing.

We are advocating the opposite, namely that facilities have primary communities of reference and are integrated functionally into a network of services in the community. This primary catchment area responsibility is not in conflict with highly specialized services serving, for efficiency and effectiveness, specific needs of small community areas, but relating their services and ongoing child care to the facilities in these communities.

We wish to clarify however, that our committee does not place high priority on the provision of institutional care. In an interview with the Executive Director of the Mental Health Division of the Department of Health, we asked whether the plans proposed in the White Paper call for increased residential treatment programs. We agreed with him when he responded that more treatment beds will not provide the solutions to all the problems about which we were mutually concerned. The pressure for more 'beds' probably reflects a narrow view of the community services that are required to respond to children's needs and the'visibility' impediment referred to earlier.

Day care treatment programs We believe day treatment for disturbed children could become the most common treatment mode if a major policy shift were to occur. At present its expansion is hindered by the practice of calculating treatment costs by bed-days in the manner of a hospital. With an effective day treatment program, residential care could be used more often for crisis-oriented short term stays.

In the movement for the creation of community Mental Health Centres in the United States, the component that was most

poorly developed and projected was that related to day care. This reflects a curious schism that exists in the mental health field; a schism with the proponents of out-patient treatment on one side and in-patient treatment on the other. If one or two hours of therapy a week is in-sufficient, then, so the argument goes, the patient needs twenty four hour, seven days a week care; and in the children's field there has usually been the insistence by treatment agencies that this be for periods electively of two, three or more years. This situation has been fostered by a tendency to follow the identification of problems by the creation of residential facilities which are attractive both to the public and to the legislators.

Simultaneously there has been an increasing appreciation that the unit of concern should not be the child alone, but those social systems of which he is part and which have impact upon him. Disruption of these systems causes at least as many problems as it temporarily solves. Undoubtedly there are children who require more than the usual out-patient therapy. What is badly needed is a continuum of services of graded intensity and variation. Day treatment provides this possibility, as children can attend programs for different periods of time, depending on their individual needs and their stages of progress. The vast majority who are labelled as needing residential care, can in fact be dealt with as effectively by day treatment and at something between one third and one sixth of the cost. It also utilizes a considerably smaller number of professionally trained staff who are scarce. Further it requires the active participation of the family, which is less essentially an ingredient in residential treatment. Day treatment in all cases should have a major educational emphasis. It is a collaborative endeavor between several disciplines to produce an atmosphere conducive to cognitive and social re-learning. At present this development is impeded by the absence of appropriate funding mechanisms for its financial underwriting. It can become the main institutional representation in a continuum of services, with residential treatment being a back-up to other services, brief in duration and crisis oriented. As presently utilized, however, day treatment is usually seen as serving a different population from those requiring residential care.

The arguments for day treatment are strong. The capital investment is minimal and it can often be instituted in existing community buildings. Its effectiveness, its therapeutic potential in bridging the gap between out-patient and residential care, and the fact that it can be instituted with a minimum of overhead cost and new con-struction are greatly in its favor.

We believe that day care should receive greater emphasis than residential care, and that facilities to provide this should be located and decentralized throughout the community being served. We therefore recommend that mechanisms for establishing day care facilities for the treatment of emotionally disturbed children in communities across the province be developed and implemented.

Correctional services In a letter received from the Deputy Minister of the Ontario Department of Reform Institutions (now known as the Ontario Department of Correctional Services) there is reference made to implementation of the White Paper.

> 'Although the primary identification of the mentally and emotionally disturbed child will be done by the court prior to committal, there may be some children who will show signs of being disturbed after admission to the training schools, and some may elude the screening facilities of the court or community. We therefore feel that one of our prime requirements is a classification and assessment unit, and this is one of the major requirements of our department mentioned in the White Paper. As a result we have acquired property in Oakville and the preliminary drawings for a Reception and Assessment Centre for our training schools system have been approved.'

The apparent intention is to identify children who are seriously disturbed so that they may be referred for special treatment programs under non-correctional auspices instead of continuing in the training school program. We thoroughly endorse the concept, but if many children are so identified we cannot help but wonder where the specialized treatment will be available in view of the present dearth of such facilities for adolescents, and the equally valid demands for it on behalf of non-delinquent children.

The shortage of adolescent care facilities affects the training schools in several ways. Firstly, training school staff, court officials and agency workers alike acknowledge that some children are being committed to training schools not because this is the service which can best meet their needs but because there is simply no alternative. Secondly, shortage of adequate foster home or group home accommodation sometimes results in children being retained in the schools beyond the point where release is timely and appropriate: understandably the effect on the child can be devastating. Thirdly, there are children who need specialized care of a type which the training school cannot or should not be expected to provide, but those facilities which do provide this care are limited and constantly overcrowded.

We earlier described White Oaks Village, a training school which provides a unique experience for very disturbed children. Other training schools in Ontario have equally attractive programs. In fact, when consideration is given to the fact that of all the children's institutions in the province the training school is the only one which cannot afford the luxury of a selective intake policy, but must accept all who are committed to its care, the progress which is made with many children is quite remarkable. It is indeed sad to contemplate that all the effort, involved in effecting this progress, can be rapidly and totally nullified, if the child is returned to a community which lacks the supportive services necessary for his continuing care.

Further efforts should also be directed toward keeping the child out of the corrections stream. Therefore, we recommend that community services be examined with special reference to the availability of adolescent care facilities such as those available in in-patient and out-patient facilities in hospitals, mental health clinics, residential treatment centres, day treatment centres, counselling services, foster homes and group homes, with a view to planning a range of appropriate services to meet the needs of adolescents.

If these facilities were available, there is little doubt that the pressure from the corrections stream for admission of children to residential treatment programs would be lessened. We particularly wish to stress the value of day care programs as a placement facility for children leaving training school, who are ready for discharge, but need special help.

Educational Services The Superintendent of the Supervision Section of the Ontario Department of Education provided us with a succinct explanation of his department's role in the implementation of the White Paper.

> 'The Department has appointed Regional Consultants - Special Education, to the eight Regional Centres established by the Department of Health. The Regional Consultants work with members of the clinic staff to devise the most effective treatments. They do this by completing an educational diagnosis for each child referred, making this known to the teacher concerned and helping her to integrate the recommendations of the clinic with the instructional program of the class. The academic progress of each pupil is followed and the clinic staff are informed of unexpected occurrences in his school life.

The number of children referred by the clinic staff to the Regional Consultants, Special Education is reported regularly to the Department of Education.

The Department of Education has provided each consultant with books and materials for use in preparing the educational diagnosis and in advising the teachers of children referred to them. The Department of Education has also made available to these staff members an office and secretarial assistance, and provides for their salaries and expenses. Wherever possible, the clinics have given office space to the consultant.

The Regional Consultants, Special Education, function as members of the clinic team. They are responsible to the director of the centre and accept referrals from him. At the same time, they maintain a professional liaison with the appropriate regional education office. The work of these officers is co-ordinated by the Provincial Supervisor, Special Education, with special responsibility for the emotionally disturbed.

Each Regional Consultant, Special Education, sits on the local Expert and Technical Committee.

The Department of Education welcomes its association with this cooperative venture in making provision for children with mental and emotional disorders. It has no intention of regarding its responsibility discharged with the fulfillment of its commitment in the White Paper. Further efforts will be made to help school boards in the extension of services to handicapped children. No doubt the introduction of county boards will make a significant contribution to the goal of providing equal opportunities for all children whether handicapped or normal.'

Educational liaison role We endorse this liaison role, because we wish to stress the importance of providing a link between the school serving the child while he is in an institution, and the school to which he returns in his home community. However, the eight liaison officers who have been assigned to Regional Centres, are not responsible for the educational follow-up of all children in the province who leave hospitals, training schools, and residential centres.

We suggest that liaison can be established between the school in a residential treatment setting and the school to which

the child returns when he is discharged, whether or not special liaison personnel are available. This would require that the personnel responsible for easing the child back into his home community, recognize that a successful school transfer is facilitated if the teacher receives adequate guidelines for the preparation of a suitable educational program. The personal experiences of some of our members bear out the fact that teachers often have many questions to ask that go beyond the scope of information contained in records. We suggest that in general, the home teacher should be given the opportunity to peruse the child's academic records and address questions to the liaison person, or the teacher who formerly taught the child, prior to the time that the child is admitted or re-admitted to his classroom. We therefore recommend that liaison between the school serving the child when he is receiving treatment in a residential setting, and the school in the community to which he returns be strengthened to ensure that the home teacher will receive adequate information upon which to base a suitable education program for that child.

Education in residential treatment centres When representatives of our committee visited one Regional Centre in Ontario, they noted that the educational facilities of that children's centre were financed by the Department of Health. There are, we understand, several methods by which education may be provided in a treatment centre or hospital.

The Department of Health may operate the program. An example is the school at the Kingston Psychiatric Hospital.

The Department of Health may purchase education from an outside agency. An example is the purchase by Thistletown Hospital of education from the University of Toronto through the Institute of Child Study.

The Department of Education may provide the educational program as it does at CPRI in London.

The local school board may operate the school for the hospital as does the Hamilton Board of Education for the Chedoke-McMaster Complex.

The hospital may have its own school board and operate its own school as occurs in Ottawa at the Royal Ottawa Hospital.

As a principle we support the idea that children who are in residential treatment facilities, wherever possible and when it becomes appropriate, receive their education in the local public schools. However, as it is difficult to apply this principle in all instances during the total length of stay, alternative provisions for education programs within the hospital or other residential treatment facility need to be made.

Another possibility that we think should be considered, is that of offering the therapeutic benefits of the classroom in the residential facility to children in the community who have special needs. This would be one way in which the treatment program could be extended to provide a day treatment program. However, it should be noted that flexible arrangements that permit either type of educational experience, depending on the needs of a child, require ongoing communication between the staff of the treatment program and the staff of the local public schools. The successful implementation of such a plan requires that teachers have ready access to consultation about suitable educational programs and special problems as they arise.

There are advantages for the teachers of the school operated in the treatment centre when the school is considered to be part of the community. The teachers may attend the professional meetings of the local academic community, may have consultants visit and may have their teaching experience in the special setting counted for salary purposes. When teaching in an institution is made as attractive as teaching in a public school, there is increasing likelihood that capable teachers will apply for the positions.

There is another obvious advantage to the idea of using these facilities interchangeably, as it provides a means of reducing the present social isolation of in-patient units and other residential treatment settings. Frequently, in our committee discussions, members voiced their concern about the tendency to cut the child off from community life while he is receiving treatment. We believe that further recognition should be given to the benefits to the child when he is given the opportunity to participate in the life outside of the institution where he is receiving treatment. We therefore recommend that Boards of Education and staff of residential treatment facilities explore the possibility of effecting flexible arrangements that would enable children to attend school in the institution or in the community on an inter-changeable basis.

The courts In response to our request for information, the Assistant Deputy Attorney General enclosed a summary report

of his department's involvement in the implementation of the White Paper during the past year, 1967 - 68. We quote from this report.

> '...a primary liaison supervisor has been designated to liaise on a permanent basis with each of the eight centres.
>
> Local committees have been developed under the Regional Medical Officer of Health of which they are members. Even prior to the identification of the local committee membership, referrals had already begun on a fairly large scale in some centres where due to available staff and facilities they could begin to accomodate Probation Services and Court referrals. In one three month period twenty four cases were handled. The actual referrals entail a considerable amount of work in terms of preparing social histories, continuing liaison with the Centre and attendance at case conferences.
>
> The type of collaborative effort in which we are engaged is welcomed in the interest of an improvement in administration of both social and legal justice in relation to those youths appearing before the courts to the end that both diagnostic and treatment and sentencing facilities of the Courts may be improved for the good of those individuals appearing in these Courts, and the wider community.'

Diagnostic and treatment facilities in the juvenile courts
Our committee was concerned about the general lack of diagnostic and treatment facilities in the juvenile courts of the province. The history of such services, even in the larger urban areas, where there are specialized juvenile courts, indicates that they have had their ups and downs, periods of extension, contraction and even disappearance. We were therefore forced to conclude that it would be unrealistic to recommend that these highly specialized services be tied in solely with the court.

We believe, however, that these services are essential to the courts and wish to draw attention to the necessity for effecting suitable arrangements for a combined community approach to the provision of diagnostic and treatment facilities to the courts.

Probation services Ontario is acknowledged to have one of

the best probation services in the country, in terms of extent of coverage as well as quality. One aspect of the development of the service that has been consistently progressive, deserves special mention - the staff development program. Among the entrance requirements now applicable within the Provincial Probation Service is a degree of Bachelor of Arts or equivalent. It permits the acceptance into the service of applicants with a wide variety of backgrounds, who often bring to the job knowledge gained through previous experience in other fields.

The six phases of the in-service training program provide opportunity for up-grading skills, staff advancement and keeping senior staff up to date. The approach in terms of flexible admission policies, staff development, and career levels could well be seen as a model for recruiting and training personnel in some of the helping professions that are relevant to the provision of integrated community services for children.

Regional committees In conclusion, we wish to comment briefly on the roles of Regional Expert and Technical Committees outlined in the White Paper on Services for Children with Mental and Emotional Disorders. Page 5 of the White Paper makes reference to Regional Committees under the heading of 'co-ordination'.

> 'The regional centres will be a focal point in the co-ordination of regional and local services. By the secondment of staff representing each Department to each regional centre, a close working liaison will be established which will extend out into the community.
>
> At both the regional and the local levels, a co-ordinated use of services will be sought in relation to the needs of each individual child. Expert advice and technical assistance will be provided by regional and central officers of the five represented Departments of Government to local groups striving to develop a co-ordinated program of services within a community. The local medical officer of health or in the absence of a full-time medical officer of health, the regional medical officer of health will assume the responsibility of co-ordinating officers at the local level.'

In our visit to one Regional Centre we found that the Regional Expert and Technical Committee with whom we met was apparently struggling with an enormous responsibility - the complicated

task of initiating dialogue with local groups. This Committee seemed to feel that, once local groups became aware of their existence, they would be bombarded with requests for information related to extension of treatment services for children. This may be true, but our committee was concerned about the absence of a sense of reaching out to community groups and somewhat sceptical about the potential for bringing about local action 'from the top down', particularly as the Regional Committee has no control of budget and cannot make policy decisions.

At this same meeting we put certain questions to the members of the Regional Committee in terms of their liaison functions and responsibilities, and found some difficulty in having this clarified. For example, we did not ascertain how each Department's representative followed up cases after treatment, or how community resources were being used. We recognize however, that it was probably too early to expect clearer definition of new roles and new approaches to services.

If given the opportunity to work out their roles both individually and collectively, in time the liaison arrangements called for in the White Paper could considerably strengthen the continuity of care provided for children in each Region.

THE WAY IT OUGHT TO BE

T H E W A Y I T O U G H T T O B E

THE GREATEST CHALLENGE

THE PRE-SCHOOL YEARS

THE SCHOOL YEARS

NEW DIRECTIONS

THE GREATEST CHALLENGE

The extent of the problem

Prevention as a concept

THE GREATEST CHALLENGE

The extent of the problem

The Ontario Committee has been reluctant to search for ratios which may imply that certain criteria should be used in the selection of children for whom segregated programs are thought to be necessary. At the present time, placement of children in special classes and other segregated facilities is a fairly arbitrary process. It is greatly influenced by whatever professional disciplines happen to be involved in identification, diagnosis or assessment of disorders, and often depends on what remediation and treatment facilities can be mustered in the community. Recognizing that the majority of approximately 2,000,000 pupils enrolled in Ontario schools will not require special educational programs, we were particularly reluctant to draw on any data that would infer that more special classes are required in the school system.

The lack of uniformity in classification of emotional and learning disorders makes it almost impossible to base an estimate of the extent of the problem on available statistical data. Even where it is possible more precisely to define handicaps, as with blindness or deafness, new approaches are now being taken to meet these specific needs. These approaches further complicate a collection of data that relies heavily on a count of numbers of children enrolled in special programs according to classification. For example, we learned of a pilot project, in one community, to integrate twelve blind children into the public schools. This is a new development in an already existing trend. In the past, individual blind children have returned from the Ontario School for the Blind, Brantford, for their senior years of high school, and a few blind children have attended regular kindergarten programs. But this is the first time that a plan has been developed for legally blind children, who must depend upon the use of braille for their education, to attend public schools, and to be taught by regular teachers in grades three to twelve.

Implicit in our focus throughout this document is the emphasis on functional programs to meet children's special needs, and a de-emphasis on programs that are designated by specific diagnostic levels. We therefore feel that in general there is little to be gained by categorizing or labelling children for special class placement.

But, 'How can you plan without knowing the statistics?' is frequently asked. We believe this a valid question, but

are suggesting that it can not be answered on a provincial level. In exploring potential resources for statistical data that would help us to determine the extent of emotional and learning disorders in children in the province, we found that there are many problems related to collection of data even within any one jurisdiction. For example, we found that the Ontario Department of Education asks school boards to report the number of pupils in attendance on September 30th and these figures are the basis for the statistical reports for the school year. The Department also asks school boards to report the number of special education classes and the number of teachers employed who possess certificates that permit them to give service on an itinerant basis. But the Department does not collect figures for the number of children registered in each special class nor for the number of children being taught by an itinerant teacher.

There are other factors which make it difficult to determine the number of children and youths in Ontario who, because of unusual needs, receive or require special educational treatment. Among the difficulties surrounding the collection of data on the number of handicapped children being served in the schools are

> frequently, children are moved into or out of programs as their needs are recognized and the indicated adaptations are made;
>
> minor alterations in a child's educational program are often not brought to the attention of senior administrators;
>
> the definitions used in classifying children in Ontario are not necessarily the same as those used in other jurisdictions;
>
> in the Ontario statistical report, a class in the category 'emotionally disturbed' must conform with certain criteria. A school board may operate a program adapted to the needs of the children in it, but, because of some deviation from the official requirements, it cannot be reported in statistical reports as one for emotionally disturbed pupils.

In the light of these considerations and developments we recommend that each community should itself conduct a survey of what appears to be the extent and specific nature of problems as the initial step in planning to meet the needs of children with emotional and learning disorders.

The national Study Committee of this Commission, in its

conduct of a major study of Incidence of Emotional and Learning Disorders in Children, found that most studies in Canada and other countries, point in the direction of an upper limit of 10% of children classified as emotionally disturbed or having a learning disorder. Some studies indicated an incidence rate of 15%. In the face of this evidence, we cannot conceive of meeting the needs by following a segregated pattern of delivery of services. The answer must be found in a more efficient deployment of available professional personnel, the increased use of less highly skilled personnel, and a community oriented approach that will ultimately result in decentralization of services, and strengthen communications between all the agencies serving children in the community.

The area of prevention however, represents the greatest challenge. Its rewards are not seen for many years. It is as yet a relatively unchartered area. It has not yet acquired the glamor of other activities. But it is the only possible, likely and practical way of ever coming to grips with the gap between services available and needs of the population.

Prevention as a concept

Although prevention seems generally to be regarded as related to the first few years of life, it is, in fact, an ongoing process, in which schools have disproportionate opportunities to have an impact and for tailoring, to an understanding of the child's developmental capacities and individual needs what is offered in school programs. In adolescence, the preparation for family and for the assumption of the responsibilities and rewards of maturity can set the stage for the promotion of a healthy environment into which the next generation of children will be born.

At all points in this cycle there needs to be emphasis on prevention, although the agents and mechanisms vary with the stage of development. In the early years the approach is largely through medical care, with attention to the family's needs as well as the child's. In the middle years the school interest becomes predominant, and in adolescence the social agency, clubs, organizations and formal and informal peer groups have the most influence. At each point there is aid for those who carry the prime responsibility and provide the essential ingredients. But the essence is true collaboration between equal partners each recognizing his own and his counterpart's contributions and the way in which together they are more effective than when separated.

The processes of prevention require not only leadership, but support, and, in particular, require guaranteed long-term financial support from public funds. It is important that we make this statement in an uncompromising fashion, particularly as the availability of funds seems if anything to be moving in the opposite direction. It also requires that time be taken from other activities and given to prevention, and that the financial rewards for those concerned with prevention should not be, as at present, lower than for those involved in intervention and remediation.

Prevention will not move ahead until there is a commitment to it; a public, political and professional commitment. The longer such commitment is delayed, the more the difficulties will compound, resulting in increasing demand for service, increasing toll in numbers of the population who are handicapped. Delay will perpetuate the present frustration and guilt resulting from the inadequacy of the present methods of providing care. Services cannot survive without support of an interventive nature, but intervention will crumble under its own weight if it is not relieved by preventive care. One can tinker with the old engine only so far and for so long. We have to encourage the public to look at a new model, even if in the interim it means providing less of what they immediately and quite understandably demand.

THE PRE-SCHOOL YEARS

Prevention

High-risk groups

Accessibility and availability of services

Family planning

Day care

Provisions for day care

Preventive possibilities of day care

A total service concept in day care

Examples of pre-school programs

Summary

THE PRE-SCHOOL YEARS

Prevention

It is regrettable, but none the less true, that developments in the area of prevention in mental health have been notably lacking, although the need is even more pressing than in the physical health area. Despite the fact that the major improvements in physical health have developed much more from prevention than from interventive activities, e.g. polio vaccination, mental health practitioners have been reluctant to move into this area.

The numbers in need vastly exceed the capacity of services, and this is particularly true of services provided for children and adolescents. It is almost futile to hope that we will ever catch up with the needs even by multiplying our services by a factor of ten. Yet prevention has been 'unstylish!' It has had to compete with the professional stance that attached highest importance to long term intensive intervention in social work or psychiatry. Perhaps the absence of definitive facts has led to support for this position. But even where the facts are known, appropriate activities have not developed. Further, public pressure or even professional pressure, has always focussed on intervention in respect to children who are the most troublesome. Or, demands have been made for increased services in areas of special interest. There has been a never ending process of 'nibbling away' at the problem, which becomes larger as the population expands and increased needs are defined.

The answer is not to be found in shuttling available services from one place to another, particularly if they are forcibly and inappropriately deployed. The effect is at best dubious and negligible. Nor is the answer to be found in playing the 'responsibility game'; that is, the assignment of responsibility without the resources to discharge it. This is a 'con-game' in which the victims are clearly those who are supposedly helped. The increasing number of adolescents in mental hospitals who are receiving treatment under conditions that have little relevance to their needs, is a well known and repeatedly emphasized problem created by this mechanism.

Services cost money: the more visible and tangible their effects, the more readily money is available. Prevention is undramatic, difficult to validate statistically, and lacks appeal. It wins less support from parental groups, and it is not experienced as a pressure area by professionals. Little

then that is significant gets accomplished. Much needs to be done, but two key elements are essential before anything effective will be achieved. The first is a clear commitment by professional groups, that this is an appropriate, respected and valued area, and consequently an essential component of trainee education. The second is the commitment of public funds to these activities, distinct from funds allocated for treatment services of a more traditional nature.

Although primary preventive services must be organized and synchronized with those of secondary and tertiary prevention they will rarely be effective unless specific staff are allocated to these activities, and have protection against the demands made on them for intervention. In organizational terms, then, the most effective manner would seem to be to have a central core staff responsible for the organization, integration and evaluation of preventive activities with the understanding that the total staff will be utilized in the provision of these services. Often intervention and prevention can be at loggerheads. Prevention is too important to be left to chance. It can only succeed when the whole organization makes a commitment and honors it by giving staff time to activities in this area.

The whole area of prevention requires a combined multi-disciplinary, multi-organization, multi-agency endeavor. In the early stages, the most feasible approach at the moment is through improved medical care in pregnancy, and better care of infants immediately at birth, with emphasis on detection of defects and the development of appropriate programs for those so identified. The main agents are the practicing physicians, obstetricians, pediatricians and public health nurses, who carry the front-line responsibility for care during the pre-school years.

High risk groups

Some physical, behavioral and intellectual problems in later life may be directly attributed to the lack of care received during pregnancy. Special groups can be identified as having a greater risk of inadequate care during pregnancy and therefore of complications and consequent damage to the unborn child.

Among the special groups who can be so identified are unmarried mothers. Children of unmarried mothers may constitute an easily identified group of high-risk infants born in the province. Information in a report prepared by an Ontario Committee for the National Maternal and Child Health Conference held in Ottawa in 1967, is of interest.

'In 1964 there were 7,188 live births to unmarried mothers in Ontario. Approximately 24% of these mothers received care in the 13 homes for unmarried mothers in the province. Most of the homes are sponsored by religious organizations, and all are supervised by the Ontario Department of Social and Family Services and are eligible for financial assistance under the Charitable Institutions Act. More than half the mothers accepted were under 19 years of age, and students formed the largest group of admissions, due to the selection by the homes of girls who, it is felt, will benefit most by the services offered.'

These homes operate at full occupancy throughout the year, and although there appears to be a need for increased accomodation, the cost involved acts as a deterrent. Over 90% of the infants born to mothers cared for in the homes are placed for adoption. Practically all these adoptions are arranged through the Children's Aid Society.

The number of unmarried mothers who do not seek admission to one of the homes or do not receive prenatal care through an obstetrician, family physician or hospital clinic, is unknown.

Accessibility and availability of services

This same report discussed those who avail themselves of prenatal services.

'Between 5% - 26% of expectant mothers attend prenatal classes in areas with full time health services. But the mothers who attend these classes are usually married, in their early twenties, have completed high school and are in the middle income group. The unmarried woman rarely attends prenatal classes in the community.

In the areas where there are full time health services, expectant mothers may receive a pre-natal visit from the public health nurse. However, those visited consist mainly of 2 groups: women who have attended prenatal classes, i.e. married in their early twenties, in the middle income group; and at the other extreme the mother of a family that is receiving regular visits from the public health nurse, and other welfare agencies.

It is generally accepted that the public health nurse, or the Victorian Order nurse will visit

> mothers in hospital, or obtain the names of patients requiring home visits who are referred by the physician or hospital nurse, or social service departments of larger hospitals. But once the unmarried mother leaves the hospital, little information is available regarding her return into the community.'

The report supports our initial assumption that the people who use maternal and child health services are those who know how and where to seek help. Because they lack adequate financing, or are unwilling to expand their programs, public and private child health agencies do not go out of their way to publicize the services that they offer. In fact there is a 'closed door' policy for some potential consumers who do not 'qualify' for service. This point is well illustrated in the selection process used by the Homes for Unwed Mothers. Yet all of these homes come under the supervision of a department of government and receive funds through government channels.

Family planning

On the subject of family planning the same report tells us that the family physician and the obstetrician are the people most actively involved in providing information on family planning. In some of the larger cities, some hospitals have family planning clinics. Only three of the official health agencies have established such clinics, others supply information on request. Only one private agency runs a family planning clinic where information is given, the various methods supplied and the patient followed up. It is difficult to assess who uses these services but it is probably safe to assume that since they are not widely available, or highly publicized, the very people who need help most do not avail themselves of the service.

The information gleaned from the report helps us to conclude that pre-natal and post-natal care, infant care and family planning under public and private auspices should be promoted to stimulate attendance of citizens from all walks of life. This would enable a realistic assessment of need as a basis for planning future expansion and adaptation of existing programs.

Day care

For the latter half of the pre-school era, more and more programs of day care are being instituted.* For a long

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* Reference is made to 'day care' a necessary component of community services for children, as distinguished from 'day care treatment programs' which are relatively specific in their focus on remediation.

time day care programs were hotly resisted on the basis of the false philosophy that all children are better with their own mothers until they reach school age. This is a highly dubious belief and in fact studies of day care show children functioning at levels higher than those who have not had this experience. 1 2 There is also good indication that for the mother who wishes to work, it is preferable that she do so rather than feel compelled unhappily and resentfully to remain at home. However, it is important to note that day care programs are a potential area for exploitation and need to have adequate standards, supervision, appropriate space, play materials and trained staff.

Ontario is the only province in Canada that has claimed federal matching funds to provide a system of provincial grants for the operation of municipally sponsored day nurseries. The provisions of the regulations under the Ontario Day Nurseries Act/1966 call for licencing.

> 'All nurseries, day nurseries, private kindergartens, not operated by a public school or separate school board or registered under the Department of Education Act, are required to obtain a licence from the Department of Social and Family Service.'

Roughly there are two types of day care programs operating under the legislation:

> day nurseries providing group care for children two to school age;
>
> day care for school age children that provides before and after school care and a noon meal.

But family day care to provide care for children who are not old enough or for other reasons cannot fit into a group program does not come under the legislation.

In 1966, 18,350 children were enrolled in licensed nurseries in Ontario. Of this number, 5,470 were supervised throughout the day, while the rest attended for half-days only. Accommodation used for nurseries included churches, houses, operator's own homes, public halls, school buildings, and buildings constructed as nurseries. Nurseries are oper-

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1 Richmond, J.D. Communities in Action A report of Project Head Start in: Journal of Pediatrics 37 905 1966

2 Waller, D.A. & Conners, C.K. A Follow-up Study of Intelligence Changes in Children in Project Head Start 1966 Child Development Laboratory, Massachusetts General Hospital

ated under a variety of auspices which may be grouped as follows; individuals or partnerships, co-operatives (parents), private agencies (churches, social agencies, etc.) and public agencies.

Since 1967 new legislation provides two ways in which grants are payable to nurseries.

> A nursery established and operated by a municipality may receive 80% of cost of renovation and operation.
>
> The municipality may purchase service from a private nursery on behalf of children whose parents qualify as 'persons in need.'

Provisions for day care As far back as 1958, a Department of Labour report indicated that about one-half of the married women who are employed have dependent children, and suggested that their major reason for working is financial need. [1] A more recent study of needs and resources of Metropolitan Toronto found that:

> 'The real issue then, is not whether mothers should work but rather the need to ensure that children are cared for adequately while mothers are at work.' [2]

Although there are a variety of day care programs in operation, it is difficult for a working mother to make adequate arrangements for her children even in a large urban centre. For example, in Metropolitan Toronto the majority of nursery schools provide half-day programs and are suitable only for women who work part-time. Some women who work full time use the half-day nursery facility and make other arrangements for the rest of the day. There are some full day programs but these are relatively few in number. A few junior kindergartens, established as part of the regular school program under the Public School Act, accept children at four years of age, but these are half-day programs too.

For a woman in full-time employment, whether she has pre-school or school age children, the problem of arranging for the noon meal and after school supervision is not easily solved. For this reason many children are placed in private homes in the neighborhood. Although the care may be adequate, there are no licencing requirements, and there is no inspection carried out to ensure that reasonable standards of care are being met.

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1 Married Women Working for Pay in Eight Canadian Cities Department of Labour, 1958 Queen's Printer, Ottawa

2 Needs & Resources Study Social Planning Council of Metropolitan Toronto 1963

Despite the expression of need from all directions, it is very difficult to ascertain the actual extent of need for day care services in the province. The Women's Bureau of the Federal Department of Labour has found through its surveys that there is a natural tendency for mothers to be cautious and reserved in replying to questions about the care of their children. This may in part explain why there is less demand for organized child-care facilities than one would expect in the circumstances.

Although there is enabling legislation in Ontario, there are some formidable barriers to the expansion of organized day care services. Communities often find it difficult to determine the actual extent of the need for services, although they may recognize that the need exists. Often too there is considerable uncertainty as to the form the services should take. Shortage of qualified personnel, prohibitive zoning regulations, or the capital cost of establishing day nurseries are frequently mentioned as inhibiting factors. The lack of sufficient quantity and variety of these child-care facilities might also be attributed to more subtle forms of resistance. Although industry and business actively recruit female workers, there is token or 'lip-service' acceptance of the fact that large numbers of married women are returning to or entering the labour force. This refusal to face reality may be the real obstacle to the provision of day care facilities.

Preventive possibilities of day care Day care in a variety of forms has strong possibilities for prevention. It can enhance the process of socialization of the child and introduce him to more diverse groups. It can enrich his fund of knowledge and curiosity, since it complements and often supplements what the family can provide directly. In general it can prepare the child both intellectually and socially for entering school.

Day care can also be tremendously supportive of families through periods of emotional and physical health crises. It can provide the means for a 'head start' to overcome some of the difficulties due to a maturational lag that some children encounter when they enter school. A properly designed day care program can provide for the special needs of children who require more than the usual care and management at home. For parents of mentally retarded or physically handicapped children, day care can provide the relief they need to cope with problems of an ongoing nature.

In general however, day care should not be seen as a problem oriented program, but as a major component of community services for children. The service should be located in the neighborhood, just as close to home as the neighborhood school, and should be as financially accessible as it is

geographically accessible. Services should provide nursery programs on a half and a full-day basis, before and after school care for children whose parents are away from home during the day, and care for children too young to enter a nursery school program. Counselling services to parents, as back-up to the program, provide an added plus to the service.

A community requires day care programs in a variety of forms to fill general, specific and specialized needs. We are therefore reluctant to recommend that all such programs belong under any one specific auspice. We believe however, that some of the pre-school programs provided under the auspices of boards of education have an advantage over welfare day care programs since there is no direct cost involved for the parents, and no means tests are required to determine eligibility. Thus the public school programs emerge as a social utility for the neighborhood.

A total service concept in day care Since we have stressed the values of day care in its many forms, we were interested to learn of an agency that provides a broad range of day care services. In using this illustration however, we do not imply that all such programs should be developed on a total service concept, since we believe the priority need is for a basic day care program which can call upon specialized consultation and help as needed.

Sponsored by a voluntary community agency, the program of the Victoria Day Care Services in Toronto provides family day care, nursery school and family counselling services and makes use of volunteers as helpers.

Children and families are identified for whom day care becomes an urgently needed service. The chronic welfare families, the culturally deprived and the handicapped are joined by the large group of economically stable families whose mental health needs require community sharing of child-rearing responsibilities.

The group program with its early childhood education concept, its daily contact with the parents, its special emphasis on child development is enhanced by the availability of family day care. The provision of both kinds of day care services has increased the ability to meet the individual need of clients and to enable a wider range of families to avail themselves of the service. The aim is a total service concept, regardless of the initial base on which the care service is requested and offered.

Age limitations for children are fairly flexible enabling

after-school care and continuing service even when children have 'graduated' from the group program of the nursery school. Day care is also made available for children who are too young to be admitted to a group program. Families can use both services with complete mobility between the two. Single and central casework services are available, no matter which programs are selected. The program is operated throughout the year.

Examples of pre-school programs

Our Committee learned of various programs that were of interest to us because each one had a slightly different focus on meeting needs of children in the pre-school years.

In Oshawa, a program to prepare hard of hearing children for regular kindergarten and public school is operated by the Society for the Deaf and Hard of Hearing.

The General Lake Public School in Petawawa, has a 'readiness program' to enable slow learners to receive an extra year of instruction at the primary level in an attempt to avoid failure at a later stage.

The Ontario Institute for Studies in Education has developed a research program in an intensive academic afternoon kindergarten setting. Its purpose is to prepare children from disadvantaged home environments to succeed in first grade. The methods and curriculum are modified from those described by Bereiter and Engelmann. [1]

The Clarke Institute of Psychiatry has a program that works with autistic children and severely emotionally disturbed pre-schoolers. The nature of the principles applied and the emphasis on empirical research allows for constant evaluation of the treatment technique.

The Guelph & District Association for the Mentally Retarded in co-operation with the Crippled Children's Society and the local Rotary Club operate a nursery school for mentally retarded and physically handicapped children. The purpose of the program is to help the child develop to his maximum potential before the age of five years when he enters school if he is considered educable.

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1 Bereiter, Carl and Engelman, Siegfried Teaching Disadvantaged Children in the Pre-School Prentice-Hall Inc. 1966

Summary

We believe that top priority should be given to developing day care programs to meet the needs of young children. Day care can be a means of alleviating some of the problems that arise when families cannot make suitable arrangements for the care of their children when they are away from home during the day. It can be supportive through periods of emotional and physical health crises and it complements and supplements the home environment. We therefore recommend that provincial and municipal authorities take responsibility for further encouraging the development of a range and variety of neighborhood day care centres in communities in Ontario with particular emphasis placed on provision of care for

children whose parents are away from home during the day

children who are mentally retarded of physically handicapped.

THE SCHOOL YEARS

The school's responsibility

Levels of service

An innovative approach to services in a rural area

Identification of disorders

Diagnostic labels

Flexible and individual time-tabling

Vocational programs

Guidance and counselling services

The community-school

An 'Inner City' school

THE SCHOOL YEARS

The school's responsibility

Nearly everyone seems to expect miracles of the schools today. Many services from driver training to sex education, matters previously left in the hands of the family or the church or some other agency, are now considered to be school responsibilities. This seems also to apply to meeting the needs of children with emotional and learning disorders, since concerns which were previously confined to the field of treatment or therapy, now form part of what is expected of teachers and schools. In many respects the school has done a pretty fair job of incorporating new concepts and responsibilities into its orbit.

One of the severest critics of present day education, John R. Seeley, wrote in 1962

> 'It is not that I do not love the modern school. What a child encounters when he gets there is as decent a society as he is ever likely again to encounter: as good and decent a society as his home, if he comes from a good one; far better, if he comes from a bad. The world he meets is largely scaled to his size, tailored to fit him, tolerant within reasonable limits of his odd angles and corners, impunitive, warm and bright, unconstrictive (as far as any mass operation can be), a place fit for a child to live.'

In spite of this improved climate and the improved relationships in school today, the role of sharing in the responsibility of the emotional well-being and mental health of all young people is a very difficult one for education authorities. For the purpose of this report two very vital questions must be answered.

> Should the school assume the responsibility for children with emotional and learning disorders?
>
> Should the schools try to help each and every child no matter how great his handicaps?

The answer to the first question is undoubtedly 'yes', but it has not always been so. In the early years of this century, children with emotional and learning disorders were not so recognized and, in any event, solutions were not sought, as these 'problem' children failed and dropped out of school at an early age. It is really only since World War II that the schools have begun to cope con-

structively with children with emotional problems, and only within the last decade that learning disabilities have been defined and recognized. Ontario schools have been almost overwhelmed in the struggle to find classrooms and qualified teachers, and in the effort to develop organizational patterns, teaching methcds and training programs to meet these newly identified concerns.

The answer to the second question is also 'yes'. But the schools are now faced with the very difficult problem of what to do with children they cannot help. Some children who are severely handicapped or severely disturbed cannot be helped in a school setting, and it is important that this small minority be quickly and readily placed outside the school system when it is shown beyond doubt, that they cannot be helped within it. Appropriate placement is necessary to the well-being of these children, their families and the children who remain in school.

Levels of service

Since pioneer days in Ontario there have been good teachers who saw their charges as individuals and who took a sincere and personal interest in any child with problems. But now conditions in and out of school have made the problem much more complex, and demands on teachers are much greater. In the early days illiteracy was common and school drop-outs were no problem to the community or to themselves. To-day much more is demanded of students.

In addition the problem has been magnified by the development of modern surgery and the development and use of wonder drugs which are keeping alive many youngsters with multiple handicaps who would not have survived in the previous era.

The first 'special class' service in Ontario was established in 1911. To-day thousands of youngsters attend special classes or special schools at both elementary and secondary levels. The great drive in the last decade or two has been to provide some sort of special education program. Now the emphasis is shifting to quality of program. Because of the great rush to set up special class programs some observers feel that too many children have been placed in the segregated special programs and that many of these youngsters could and should be maintained in regular classes.

In this regard our Committee supports the statement in the Report of the Provincial Committee on the Aims and Objectives of Education in the schools of Ontario (Hall-Dennis Report).

> 'Special education should not be set up as something separate from the ordinary school program, but as an integral part of that program.'

The Committee feels, however, that it is not possible to do away with all special classes and schools at one fell swoop. Indeed many segregated schools and classes will be needed in the Ontario educational scene for some time, and experience may prove that this type of setting is a necessity for some children for a temporary period, for others for a part of each day, and for some a permanent school-life placement.

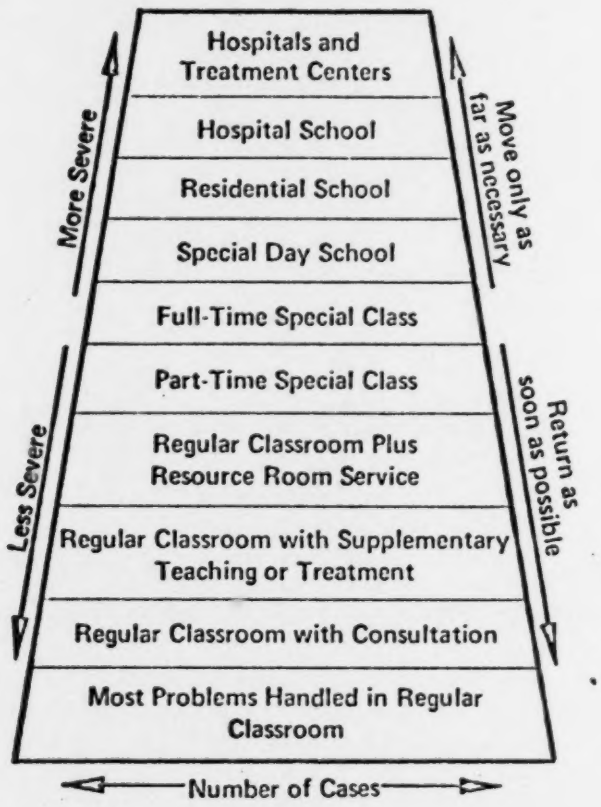
The following trends are now appearing in special education programs in Ontario.

> Emphasis on helping the child in the regular program, by assisting the regular teacher to understand and meet the needs of individual pupils in the community school.
>
> Special classes for those who need for various periods of time, a highly specialized program.
>
> The integration of almost all special education class pupils in the regular stream for various periods of time.
>
> The developing concept of 'resource room support' for many pupils who are handicapped.
>
> Greater participation on the part of the community school and its resources as opposed to withdrawing the child from his local school.
>
> Psychologists, psychiatrists, social workers, etc., serving as consultant personnel to support the work of specially trained teachers.

The placement goal for all handicapped children in school is to keep them as close to the regular classroom as possible. As teacher training improves and as non-grading and flexible curricula become more commonplace, more and more children with problems will have their needs met in regular classes by regular teachers. The following chart from a publication of the Bureau of Education for the Handicapped, U.S. Office of Education, indicates the kind of hierarchy of services required.

BUREAU OF EDUCATION FOR THE HANDICAPPED, O.E.

A FRAMEWORK FOR CONSIDERING SOME ISSUES IN SPECIAL EDUCATION*



As the chart indicates most problems must and should be met in regular classrooms by regular teachers. In the view of this Committee the factor of greatest priority in meeting the needs of school-age children is that of teacher training and the provision of professional and other supportive services to aid the teacher. If the teacher is to fulfill the expanded role we envisage for him, he must have relevant preparatory training. He must also have adequate back-up support of professional personnel in the same way that consultative help is presently conceived for teachers of special classes. We therefore recommend that appropriate action be taken to upgrade teacher training programs in order to prepare and enable teachers to meet the special needs of most students within the regular classroom, and that recognition be given to the necessity for providing consultative and other supportive services to the classroom teacher.

Most levels of service indicated on the chart are available in large urban areas of Ontario, for instance, in Metropolitan Toronto where all levels are offered. However, even in these areas it is difficult to achieve a true balance. The Committee therefore recommends that in all instances of moderate or mild handicap, efforts be made to maintain the children in

regular classes, and that the Department of Education requirement to review progress of all children in special classes or special school programs be strengthened to require such review at very least once annually.

There is a paucity of such services in most rural areas in Ontario and although it is hoped that the new divisional boards of education will fill the gaps in service, it will be some years before an adequate staff of trained teachers and supportive personnel will be available. As the initial step we recommend that divisional boards of education assign a carefully selected person to determine the need for special education services and to supervise or direct special education programs.

An innovative approach to services in a rural area

This approach to provision of services in a thinly populated area of Northern Ontario will stress the importance of bringing special services to children in rural schools.

The Education Resource Centre of the Midnorthern Regional Office, Ontario Department of Education, is primarily concerned with the principles of learning and teacher education. There is an emphasis on developing sound programs, rather than on diagnosis and assessment of specific disorders in children.

Consultative services, in-service work and resources are provided as part of the program for teachers of exceptional children. The staff of the centre include psychologists, psychometrists, social workers, remedial consultants, child development consultants, special education consultant and guidance consultant.

A reading van with remedial materials, sophisticated reading equipment and library books is hauled by truck to various schools. Diagnostic testing over a three week stay indicates students who might benefit from individual programs to improve their reading.

An attempt is made in a conference of the professional staff to translate problems into an action diagnosis so that imaginative teaching techniques are suggested and assisted within the classroom.

Identification of disorders

The matter of screening and detecting youngsters with difficulties is, of course, paramount and is closely related to referral and remedial or treatment measures. Where there

are firmly established special education systems, the classroom teachers are encouraged to identify children with emotional and learning difficulties and to discuss the child's problem with his principal and special education consultant or supervisor. Attempts are then made to modify the program and teaching techniques, so that the child may continue in his present class. If such attempts prove ineffectual, a prescribed routine of referral to the school psychological service or educational clinic for testing and diagnosis is carried out. The result of such referral may be further efforts to meet the child's needs in his present class, or referral to an appropriate community agency such as a child guidance clinic, or placement in a special class or school.

Weaknesses in this process in Ontario are evident in the lack of completeness of the screening process and in the inability of many schools to meet the needs of many youngsters who should properly be helped in their own classes in their own schools. The weaknesses become even more apparent when treatment is sought for those who require out-of-school placement because there is a lack of a range of child treatment facilities in most communities, especially in rural areas. Reference to this shortage has been made repeatedly throughout this document.

The Committee was interested in attempts by some boards of education to develop a screening instrument for use by kindergarten teachers. If successful, a procedure that would help to identify all children with special emotional or learning difficulties at, or soon after, their admission to kindergarten, may have a province-wide application. One such project is under the direction of Dr. Eleanor Long, of the Child Adjustment Services of the Toronto Board of Education, and will be concluded during 1970. In this connection, we recommend that recognition be given to the importance of identifying emotional and learning difficulties at the time or soon after children are admitted to kindergarten, and that consideration be given to province-wide application of one of the procedures being developed for early detection of emotional and learning disorders.

Diagnostic labels

Considerable confusion and disagreement exists around diagnostic terms applied to children with emotional and learning disorders. In recent years a number of schools of thought have arisen and different diagnostic procedures and educational retraining programs are being tried in response to the increased identification and rise in incidence of learning disabilities. But as we have implied elsewhere in

this document, diagnostic categories applied to emotional and learning disorders in children tend to be strongly influenced by a clinician's training and viewpoint. The diagnostic category 'perceptual handicap' is a case in point. Although there can be no doubt that a great many so-called 'normal' children suffer from early difficulties in reading, spelling and related subjects because of some form of minimal dysfunction, many informed observers claim there is not sufficient descriptive evidence to support a separate diagnostic entity labelled 'perceptual handicap.'

This view is upheld by Dr. Carl Haywood of George Peabody College, the visiting professor in Mental Retardation in the Department of Psychiatry, University of Toronto, in 1965-66. He has had considerable experience in this general field and, as well, is familiar with the Canadian scene.

> 'Commitment to any specific method of training children identified as perceptually handicapped is premature and the special education of this category of children should remain on an experimental basis.
>
> Classes for the perceptually handicapped typically include children who are more properly diagnosed as educable mentally retarded, emotionally disturbed, clearly brain-damaged, visually limited or hard of hearing.
>
> Perceptually handicapped pupils can be helped with highly individualized diagnostic procedures and instructional programs.'

The Hall-Dennis report in discussing the wisdom of establishing separate special classes for children who display the kinds of behavior thought to constitute a specific syndrome quotes Haywood.

> 'What psychologists recommend in the way of special teaching procedures differs little whether the diagnosis is high-level mental retardation, emotional disturbance, or perceptual handicap. There is amazingly little variation in the teaching methods used in these different classrooms.
>
> Dividing children into categories has the effect of labelling the child and of making him think he fits the label as one who is in some respect deficient.'

Whatever the clinical diagnosis and whether or not any medical, psychological or educational assessment has been made, there is no doubt that a great many school-age children suffer from varying degrees of learning disability. If one were to take

a count of all the pupils in the Ontario School system who have emotional and learning disorders, the total would encompass a large section of the school population.

In view of the extent of the problem of emotional and learning disorders in children, and in the absence of concrete evidence to the effect that special class placement is of great benefit to the child with special needs, we suggest that the majority of these children can and should be helped within the framework of the regular school system. There is an obvious and urgent need for teacher training programs that provide a more adequate background knowledge of child development and an understanding of the learning process.

It is true that all boards of education in Ontario need additional special education programs and additional professional assistance. But special education need not be considered synonymous with special classes. We believe a broad scale approach to the solution of the problem of meeting individual needs within the school system, should focus on teacher training and additional resources made available to the teacher. We therefore reiterate the recommendation made earlier, that the chief effort of divisional boards of education in the province be directed toward provision of in-service training for all teachers, and that consultants be made available to assist teachers of regular classes to adapt and design suitable school programs for individual pupils.

Flexible and individual time-tabling

At the present time some children return to regular grade programs after a period spent in special classes and some children with difficulties have their needs met within the regular classroom program. However, the majority of children who enter a special class or school remain in some form of segregated special program throughout their school careers. This segregation has been alleviated somewhat by the development of a variety of secondary school programs under the Robarts Plan in Ontario. The further development of composite secondary schools would make it possible for many more students, than was previously thought possible, to remain in the regular educational stream throughout their high school years. There is little doubt that as individual time-tabling and more flexibility in choice of course options become more common, less and less segregation will occur. But a variety of programs must be available within the regular secondary stream to meet a diversity of needs. We therefore recommend that composite secondary school programs be developed wherever possible.

Vocational programs

The composite secondary school provides a means of meeting the diverse educational needs of individual students, including those who are unable to advance sufficiently to cope with the more academically oriented courses. We endorse the trend to include vocational programs in composite schools as recent experience in Ontario demonstrates that occupational courses for academically retarded students and special education for educable retarded students can be successfully included in composite secondary schools.

In principle, we support the idea that children should be integrated into the regular stream wherever and whenever possible. However, we must acknowledge that there are some children who, because of the nature of their handicap, or multiple handicaps, can be provided for within the regular school system only with the greatest of difficulty. When there are large numbers of such children in a given area, as for example in Metropolitan Toronto, the Committee believes there is a place for special vocational schools. The success of these schools in recent years indicates that the benefits gained from their special equipment, special programs, and specialist staffs far outweigh any negative effects arising from the segregation aspect.

The decision to place a child in a special vocational class or school should be made jointly by the school and the helping services in the community, and by the same token, a mutual decision should be made in respect to his placement in the community when the child leaves the vocational program. Some attention should also be given to the age of admission to special vocational programs and to the question of the duration of courses. We wish to stress that we believe admission rules should be flexible enough to take care of the special needs of certain individuals, with emphasis placed on maintaining the student in the regular stream as long as possible.

The Committee also considers that it is desirable that some students in special vocational schools or programs be permitted to stay at school for longer periods of time than has been the custom in the past. Once again, flexibility should be the keynote and the duration of the course should be determined by the individual student's needs and requirements. Plans should be developed to provide four and five year programs that enable these young people to remain in school until the age of twenty-one when they can profit from such a plan. This lengthened program would place emphasis on the development of personal, vocational and social skills as well as on achievement in basic school subjects. It is important that the latter be developed to the ultimate degree, but at the same time, the school program should be as meaningful to the

student as possible. To this end, academic subject matter should be interwoven with shop activities and often based on them, especially in the early years of a special vocational program. Specialization in the technical and vocational areas, when feasible, should take place in the senior years along with practical work experience in the community.

The task of selecting students for work experience should be assumed by a placement officer who, in consultation with the principal, teachers, guidance staff etc., places the student in the area of work most suited to him, with a view to arranging full-time employment when it is considered appropriate. The placement officer should work in close liaison with local industries, and other employers in the community so that the vocational programs reflect the needs of the community. Since it may not be possible to find employment for all vocational students, and some will eventually require placement in sheltered workshops, it is important for the schools to work out an active liaison with the helping services in the community. The arrangements would facilitate appropriate placement for students, and strengthen community involvement and responsibility in this area.

In summary, we recommend that the decision to place a child in a vocational class or school be made jointly by the school and the helping services in the community and that admission rules be flexible enough to meet the requirements of individual students. Plans should be developed to provide four and five year vocational programs that enable students to remain in school until the age of twenty-one if necessary. A placement officer should be assigned to work in close liaison with local industries and other employers in the community to ensure that vocational programs reflect the needs of the community and that students are placed in the area of work most suited to them.

Guidance and counselling services

Such matters as individual timetables and flexible scheduling now put much greater demands on guidance and counselling services in the secondary schools. Guidance counsellors should be encouraged to make themselves known to the student body, and be expected to give assistance in the areas of course selection and study habits as well as personal problems, within the limits of their training. In order to help guidance personnel meet these expectations, training programs should be designed to equip them to fully comprehend their role, and enable them to distinguish between the problems they can appropriately handle and those which should be referred to other helping personnel and agencies.

In some cities, guidance teachers might have access to clinical services within the school system. But in roughly one third of the province, no such consultative back-up services are

available within the school system. In these areas it is particularly necessary for guidance personnel to work closely with other community agencies, so that referrals can be made to the helping professions where indicated. For, in no circumstances should the counsellor become involved in treatment.

Having advanced what we believe is a legitimate caution in respect to training and referrals, we wish to emphasize that we believe that guidance counsellors could perform an important preventive service within the schools. We therefore recommend that training programs be upgraded to equip counsellors to understand their role, and to clarify when and which children should be referred to appropriate agencies within their community of reference, and that a goal be established of staffing secondary schools according to the ratio of one guidance counsellor for every two hundred and fifty students.

The community-school

Schools are being used now by adults in night school programs and by cubs, boy scouts, special interest groups, etc. But the community-school, in the real sense of the word, can be established only by involving, not segments of a community, but the total community and its leadership so that the development reflects the needs and desires of the people in the community. The extent to which the school becomes truly a community-school, as the focal point for education and a centre for community life, depends on the changing role of social agencies and services as well as the importance placed upon such a development by the people of a community and the school personnel.

To be effective, the school program needs to be planned and developed by the principal and his staff in the light of the characteristics and patterns of the neighborhood. Co-operative planning with all possible agencies in the area is therefore helpful. The school will need a low pupil-teacher ratio, additional resource staff, e.g. remedial teachers, the support of auxiliary personnel such as guidance teacher, social worker and psychologist as well as additional books, supplies and resource materials. A pre-school program or junior kindergarten class, hot lunch program and before and after-school programs all help to make up a well rounded and practical community-school program.

Much of the 'acting-out' behavior that may appear to be emotional disturbance in school children is alleviated when a community-school program is developed. Such programs are expecially needed and appear to be particularly successful in inner city areas. The Committee therefore recommends

that boards of education give high priority to the development of community-school programs, with particular emphasis placed on the need for such programs in inner city areas.

An 'Inner City' school

The Duke of York School in Toronto provides us with a model of an inner city school, in that it has been wrestling with the problems usually associated with social, cultural and economic deprivation, and continues to seek new ways to meet the needs of its pupils.

The school is located in a part of the city that easily fits the description of a 'depressed' area. The school population is highly transient and a great many of the parents view the school, as they do most institutions, with distrust and even hostility.

The school has smaller classes than most, additional resource personnel, and additional budget for furniture and supplies. A large library-resource centre with its bank of non-print material complements each classroom program. An open time-table allows ease of movement to and from classrooms to help in provision of individualized instruction.

Since communication with the home is of paramount concern, parent-teacher interviews have replaced report cards. Communication within the school is also considered vital and frequent meetings of the staff allow for an evaluation of the program.

A day care project for 25 children provides for a hot meal at noon, and an after-school play program. The permanent staff of three includes a church worker in charge, assisted by volunteer nurses from a nearby hospital.

The school social worker is a key person who acts as a liaison between the home, school and community agencies. He was responsible for evening discussion groups which have since blossomed into a parent-school association. It is this role of involvement with parents and with the community that is receiving increasing emphasis.

Perhaps the attention to children's needs, and the warmth of the school atmosphere is best captured by quoting a remark made by the principal who said, 'How can one describe the fresh-fruit program of an orange a day during the winter months for the kindergarten children, or tell about hot showers, or clothing and shoes provided to students, or a hundred field trips...?'

NEW DIRECTIONS

The first step

A new point of reference

Provincial and regional facilities

NEW DIRECTIONS

The general processes that affect adversely the provision of services for children and adults in our society have been identified repeatedly throughout this report, with many specific examples of how these operate in practice. These processes are so pervasive and ingrained that certain basic changes are imperative in order to produce the improved services that our children need.

The purpose of this final comment is to summarize those fundamental modifications in policy and organization of services which appear to the Committee to be essential to produce needed change. In essence these can be considered under three operational concepts.

Limitation of the isolation of the disturbed or troubled child

Integration of services

Decentralization of responsibility and decision making

The first step

A first step will be taken in the right direction when all those concerned with the helping services are made aware and become convinced of the undesirable consequences of the isolation of children in institutions and of the fragmentation of services for them. The rapidly rising rates of delinquency, drug use and mental illness provide indices of the present inadequacy of service patterns. The report has tried to show where the defects lie and to aid helping personnel understand where things have gone wrong, or are no longer appropriate.

Once this step has been taken, there are immediate moves that can be implemented to improve care. With an acceptance of its undesirable effects, 'institutionalization' can be controlled by our current services through a focus on alternative treatment measures. And 'fragmentation' can be much alleviated by the procedure of getting agencies together regularly to coordinate their work. These things can be done now. But recognizing that we are touching on the heart of the matter and that what seems a simple process is indeed complex, we are suggesting that policy makers have a major responsibility for accelerating the pace of change to bring about a more cohesive system for provision of services. The Committee therefore recommends that all present services be advised of the adverse effects of the

institutionalization of children and the fragmentation of services by their central authorities, and that they be encouraged to engage immediately with their associates in a cooperative effort to reduce this trend. We further recommend that a major portion of currently available service resources be directed to the community which should be responsible for its own needs.

A new point of reference

The second stage of change is of a more basic nature. What has led in part to the problems mentioned above is the fact that the present services have become disoriented, as each of them found its direction from a different compass. Some services were aligned to the needs of a single school or neighborhood, some to a province, some to the nation, and many were aligned to all of these, or none. What is required by the helping services is a new point of common reference which, in our view, is 'the community.'

Communities can be defined by various arbitrary criteria, ranging from clear-cut geographic standards, to the more subtle spiritual terms which unite a church congregation. In between are a series of possibilities including ethnic, educational, economic, industrial and recreational divisions.

None of these elements are considered necessary or final to the definition of 'community', though the principle of uniting several features, if possible, may be most advantageous. The Committee has concluded that unless the 'community' is identified in our society, it will be impossible to establish services that can adapt to and respond adequately to human needs.

The definition of community will necessitate the community looking at itself in order to find out where the boundaries of jurisdiction are between the various different component services. Out of that they will have to evolve a commonality of agreement of boundaries by the different jurisdictions. The goal should be to effect a community arrangement that seems to include all services, and makes clear to the people of the community where they can turn legitimately for help.

As a guideline the Committee suggests that community services should be defined on an area-wide basis with accessibility and availability to the people who live in the area. The way of defining 'community' can be determined by a process of negotiation and by decisions as to which are the most appropriate ways of making the divisions between adjacent jurisdictions. In a number of places in Ontario it might

be feasible to use school board boundaries as a basis for defining geographic lines for the provision of relevant services. However, in some cases, school board boundaries might include too large an area, or highway routes, which have to be taken into consideration, might negate this possibility. While the school board unit is tidy, and seems to offer greatest potential for identification of community boundaries, there are some inherent difficulties in school boundaries as established at present that might not make them the most appropriate choice for some areas.

Once again, we wish to state that the policy makers have a major responsibility for accelerating the process of coordination of services. The definition of 'community' and planning for personal care services is a complex task, that should be promoted by the provincial government, and determined locally in cooperation with appropriate departments of government.

Once community services have been established they would become the new point of reference for a large proportion of human care services, including those for children. A progressive series of changes in methods and goals would follow, ranging from agency meetings for joint planning of coordinated approaches to problems, to the use of volunteers in schools and 'new professionals' in clinics and agencies. Some of these have been suggested in this report, but it is neither possible nor advisable to anticipate in detail the effect of this basic change in the focus of 'helping.'

Provincial and regional facilities

These newly oriented community services will not operate effectively without substantial resources behind them at a regional and provincial level. Throughout the document we have implied our society has 'institutionalitis.' We see it as having a highly specialized orientation. There is a major problem in serving communities. We have talked at length about developing a more adequate range of community services. At the present time there is a 'layering' of services provided at the community, regional and provincial levels. But there needs to be further definition of function, with a filter system provided at the community level. Community operations are real to the client because services are more readily accessible. They eliminate the need to travel long distances, or to place the child in residence in another city. Because the child can often remain in his own home while receiving help, they offer an opportunity for minimal disruption of family life.

For our purposes we have defined facilities for service according to catchment area.

> A community facility is one which has a local catchment area. For example, the C.M. Hincks Treatment Centre in Toronto was developed as a local community program and serves the population of that community. Group homes, mental health clinics, general hospitals serving a primary local catchment area are also community facilities.
>
> A regional facility is one which serves a region that may include several counties of Ontario and also serves the local community. Children's Psychiatric Research Institute in London is designated in the White Paper as a regional diagnostic, assessment and treatment centre serving London and adjacent counties in western Ontario.
>
> A provincial facility is one which serves children from anywhere in the province. The Ontario Training Schools which serve children committed by the courts, might be used as examples of provincial facilities in that they do not have assigned local or regional catchment areas. Many privately operated residential treatment centres also fall into this category. The Ontario Schools for the Blind and Deaf are examples of other provincial facilities.

We believe that there are problems inherent in the present operation of provincial and regional facilities that are evident but not fundamental. Their contribution to community level service will vary and change, perhaps in direct correlation to the expansion and further availability of community level services. To illustrate our point we direct attention to the relationship of community level services to the regional facilities operated and supported by the Department of Health and defined in the White Paper as 'Mental Health Services - Related to Children and Adolescents.' We believe that some redefinition of roles will be necessary to bring about a viable kind of community level interchange of ideas, referral systems and screening processes. The concerns as presently perceived are simply stated.

> Too many children are being sent to other communities for diagnosis and treatment who really could be handled in their local communities.
>
> The repetitive diagnostic and assessment procedures to which many children are subjected have become a wasteful part of agency activity.

Unless some direction is given to agencies as to how services could be better utilized at both levels so that a child can move with ease into and out of a regional facility, the difficulties noted will be perpetuated. We suggest as a guiding principle that long term treatment is probably better based in a smaller facility in the local community, and that regional facilities should be used as back-up resources for a period of time, but not be expected to carry the total responsibility for long term cases.

A rational plan for utilizing services at different levels will require further collaboration between the relevant departments concerned with services to children at the provincial level. It will also require recognition on the part of the community that it has a responsibility for the basic examinations - physical, psychiatric and psychological - before a child is referred to a regional centre. We therefore recommend that regional facilities offering service to children re-define their functions in relation to community level service and that in this redefinition there be utilization of the existing mechanisms for collaboration between the several relevant departments concerned with services to children. In addition we recommend that they have primary roles of treatment planning for cases that present major management problems in the local community, and for the teaching of methods for continuing treatment to staff who carry this out in the community. Further we recommend that regional facilities should be available for residential and day care treatment of those children who are currently beyond the scope of the community, with the objective of returning them to their community at the earliest possible time.

Finally, this Committee must add to these recommendations a recapitulation of one made earlier in this report, since without its impact the proposals made are much less likely to find their way into the helping services world, or to survive there if they do. We therefore recommend

> that the policy of government and other controlling bodies be such that the organizing patterns and funding mechanisms of service will promote patterns of service that will permit the child with an emotional and/or a learning disorder to remain in his own home, and requiring the integration of local personal care services to create a continuum of services available for all children at any age, for any need in each community.

RECOMMENDATIONS

R E C O M M E N D A T I O N S

for the consideration of

LOCAL AUTHORITIES

HEALTH AUTHORITIES

EDUCATION AUTHORITIES

PROVINCIAL AUTHORITIES

R E C O M M E N D A T I O N S

Throughout this report we have implied that services to children have grown piecemeal and are provided presently on an unplanned basis so that there are many gaps and some overlaps. In human terms the result is often tragic; in economic terms it is often wasteful.

We have stressed the importance of different levels of preventive activities, and suggested that therein lies the possible, likely and practical way of ever coming to grips with the gap between services available and the needs of the population. We have recommended that planning should be based on these major principles.

> Isolation is to be combatted by developing relevant and innovative services that permit the child with special needs to remain in his own home or community.
>
> Fragmentation should be met by a policy of integration of existing services that will create a continuum of services available for all children at any age, for any need, in each community.

The issue, as we see it, is that the policy of government and other controlling bodies must be such that the organizing patterns and the mechanisms of funding services will express and promote these principles, and enable communities to plan, develop and administer relevant services.

It is clear that there is an urgent need for the coordination of services to children, especially to those who are troubled or who are in trouble. Indeed such a need has long existed and on all sides we hear the cry for coordination. However, it is important to recognize how far reaching an effect a fully coordinated pattern of service could have upon existing agencies and government departments; and to recognize too that those who presently demand coordination might well be the first to protest if and when this comes about.

Let there be no mistake. We are not discussing mere cooperation between agencies, but something of far greater significance. Given a modicum of goodwill, cooperation is not usually too difficult to achieve because its extent is always set at a point of mutual agreement and satisfaction. Coordination however demands that someone should have the authority and power to determine the

course of events either by the provision of incentives or the imposition of sanctions.

To provide an example, we can take the case of a city in which four agencies each funded, in part by government, in part by voluntary donations, are working with similar groups of children. Agency A and B are old, well endowed but have not moved with the times in terms of their programs and tend to be very selective in their clientele; Agency C is relatively new, still struggling to exist and attempting to cope with the hard core problems of the 'tenderloin' area; Agency D is quite new with radical treatment ideas but extremely limited in applying them because of shortage of funds. All four agencies are prepared to cooperate: the lines are drawn and the territory marked; the bounds are not overstepped. An independent survey shows that Agency A could literally absorb the work of Agency B and its funds, and its workers; that Agency C and D could similarly work more effectively if they combined their total resources. There is little hope that this will ever happen unless some sanction e.g., the withdrawal of funds, or some incentive e.g., the provision of additional funds or facilities, were to be applied externally to force the issue.

It would be comforting to believe that agencies or government departments would be willing to terminate their own existence once the logic of a given situation made it evident that their demise would further the total cause. There is no point however in confusing what is with what ought to be.

It would be of some comfort to believe that sanctions applied by the voluntary contributor may have some effect. But quite apart from the naked fact that the United Appeals and Community Funds are quite inadequately funded to meet today's need, there is a widely held view that in general they have not been able to establish a rational system of priorities.

Because of the vast amounts of money which are required today to provide adequately for the needs of the children we have described in this report, there can surely be little doubt that this money must be available from public funds. We have looked at the separate funding arrangements which now exist for children in different government departments and concluded that these are unwieldy, antiquated, and do not work to the best interests of children. A look at alternative arrangements leads us to believe that this whole question of coordination and the role of government in providing or funding services is a study in itself. Therefore, we will recommend that, since it is the key

to future progress, a Commission on Children and Youth be appointed by the Government of Ontario to make such a study, and to submit a report directly to the Premier of the province. This body should study the recommendations contained in 'One Million Children' the Report of the Commission on Emotional & Learning Disorders in Children, and explore and initiate appropriate action in respect to meeting the needs of children and youth in the province of Ontario.

A series of services is required, the cost of which will initially require a substantial and increased investment in services. However, we strongly urge that any effort to increase funds for programs for children with emotional and learning disorders be preceded by consideration of the basic problems reiterated throughout this document, and that the solutions be sought in the development of a community-based design of services.

Ours is often referred to as a 'child centred' era. Our Committee in making the following recommendations does so in the hope that the citizens of Ontario will give due consideration to them in an effort to determine the best possible way to provide a fair deal for children and their families in this province.

FOR CONSIDERATION OF LOCAL AUTHORITIES

Organization of services

Day care

Further emphasis on treatment

Facilities for adolescent care

FOR THE CONSIDERATION OF LOCAL AUTHORITIES

Organization of services The Committee have concluded that unless the 'community' is clearly identified and defined in our society, it will be impossible to establish services that can adapt to and respond adequately to human needs. As a guideline the Committee sugggests that community services should be determined on an area-wide basis with accessibility and availability to the people who live in the area. The way of defining 'community' can be by a process of negotiation and decision based on the most appropriate ways of making the divisions between adjacent jurisdictions. As a first step in determining where these boundaries should be drawn, each community will need to examine its existing services and the way they function.

We recommend

that each 'community' conduct a study of the extent and specific nature of their problems in meeting the needs of children with emotional and learning disorders.

Since there is a need to restore local responsibility and involvement for services

We recommend

that community priorities for children's services be developed locally and plans to coordinate and expand relevant activities involve the participation of citizen groups and the key agencies serving children.

A community-centred approach would call for ongoing alliances and sharing of tasks by staff in schools, treatment centres and other appropriate community agencies.

We recommend

that local community planning be focussed on establishing alliances between the personnel of public and voluntary agencies that provide services for children.

We recommend

that special emphasis be placed on strengthening the relationships between the school and other community agencies.

Day care programs should be seen as a major component of community services for children, located in the neighborhood, as close to home as the neighborhood school, and as financially accessible as they are geographically accessible.

We recommend

that in each community immediate steps be taken to provide day care programs that are readily accessible to those who require the service.

Further emphasis on treatment Findings from our survey of a sample group of boys in training school point up the fact that intervention comes at a late stage and that clinical services are concentrated in the areas of assessment and diagnosis.

We recommend

that there be increased recognition of the need for ongoing treatment services in community clinics, hospitals and agencies serving children and that resources be made available to support this expanded responsibility.

Facilities for adolescent care The shortage of adolescent care facilities sometimes results in training school commitment because there is no community alternative, and children are sometimes retained in training schools and residential programs beyond the point where release is timely or appropriate because of the dearth of facilities for after-care.

We recommend

that community services such as in-patient and out-patient facilities in hospitals, mental health clinics, residential treatment centres, day treatment centres, counselling services, foster homes and group homes be examined with a view to planning a range of appropriate services to meet the needs of adolescents.

FOR CONSIDERATION OF HEALTH AUTHORITIES

Maternal and child care

Screening service in the pre-school years

Child health conferences

Day treatment programs

FOR THE CONSIDERATION OF HEALTH AUTHORITIES

Maternal and child care Pre-natal and post-natal services, infant care and family planning under public and private auspices should be expanded and promoted to stimulate attendance of citizens from all walks of life.

We recommend

that an examination of different models be undertaken to determine how programs providing pre-natal care, post-natal care, infant care and family planning services could be instituted or expanded to meet the needs of local communities.

Screening service in the pre-school years A retrospective look at the early childhood development of a sample group of boys resident in one training school illustrates the need for a screening service in the pre-school years, in order to identify high-risk children whose development suggests the presence of organic or neurological problems.

We recommend

that there be further examination of screening devices which could be utilized to identify high-risk children so that they may be assured of receiving ongoing medical care in the years one to five.

Child health conferences Child health conferences or clinics provide an excellent opportunity for early identification and detection of emotional and learning disorders in children. They also have excellent potential for continuity of health care for large numbers of children in the province who may not have ready access to the services of a private physician.

We recommend

that public health authorities examine the values of child health conferences as presently constituted with a view to setting priorities according to the needs of each area, implementing new programs as appropriate and coordinating these services with that of other agencies providing child care in the community.

Day treatment programs The arguments for day treatment are strong. Its effectiveness, its therapeutic potential in bridging the gap between out-patient and residential care, and the fact that it can be instituted with a minimum of overhead cost and new construction are greatly in its favour. Day treatment for disturbed children could become the most common treatment mode if a major policy shift were to occur.

We recommend

that mechanisms for establishing facilities for the day treatment of emotionally disturbed children be developed and implemented in communities across the province.

FOR CONSIDERATION OF EDUCATION AUTHORITIES

Teacher training and consultation

Special education

Maintenance in the regular class, of children with emotional and learning disorders

Identification at school entry, of emotional and learning disorders

Speech therapy

Remedial reading

Adding personnel to the classroom

Composite secondary schools

Vocational training programs

Guidance counsellors

Community-school approach

Liaison between the institutional school and the community school

Teacher training and consultation If the teacher is to fulfill the expanded role we envisage for him, he must have relevant preparatory training. He must also have adequate back-up support of professional personnel in the same way that consultative help is presently conceived for teachers of special classes.

We recommend

that appropriate action be taken to upgrade teacher training programs in order to prepare teachers to meet the special needs of most students within the regular classroom.

We recommend

that recognition be given to the necessity for providing consultative and other supportive services to the regular classroom teacher.

Special education There is a paucity of services that could be supportive to the teacher in the regular classroom in most rural areas in Ontario.

We recommend

that divisional boards of education appoint a specific person to plan for special education services and to supervise or direct special education programs.

We recommend

that the divisional boards of education provide in-service training for all teachers to enable them to meet the needs of children with emotional and learning disorders.

We recommend

that consultants be made available to assist teachers of regular classes to adapt and design suitable programs for individual pupils.

Maintenance in the regular class of children with emotional and learning disorders The placement goal for all handi-

capped children in school is to keep them as close to the regular classroom as possible. As teacher training improves and as non-grading and flexible curricula become more commonplace, more and more children with problems will have their needs met in regular classes by regular teachers.

We recommend

that in all cases of moderate or mild handicap, efforts be made to maintain the child in the regular classes.

We recommend

that the Department of Education requirement to review progress of all children in special classes or special school programs be strengthened to require such review at least once annually.

Identification at school entry of emotional and learning disorders The problem of screening and identifying those children with difficulties is paramount as a preliminary step to referral and remedial or treatment measures.

We recommend

that recognition be given to the importance of identifying emotional and learning difficulties at the time or soon after children are admitted to kindergarten.

We recommend

that consideration be given to the province-wide application of one of the procedures presently being developed for early detection of emotional and learning disorders.

Speech therapy The delay in identification of learning and speech disorders compounds any social or emotional difficulties that the child is having.

We recommend

that emphasis be placed on developing teacher training programs that will prepare and enable teachers to identify learning and speech disorders so that appropriate remedial help may be provided early.

Remedial reading The lack of an adequate number of remedial reading specialists in the community impedes provision of early assistance with reading to children who require it.

We recommend

that there be an examination of the need for remedial reading specialists, with a view to establishing appropriate training programs and providing incentives to recruit personnel to this field.

Adding personnel to the classroom Emphasis is placed on adding personnel to the classroom to assist teachers in meeting the individual needs of children

We recommend

that local school boards explore the potential benefits of training and utilizing both paid and voluntary aides to assist the teacher in the classroom.

Composite secondary schools The provision of a variety of secondary school programs makes it possible for many more students, than was previously thought possible, to remain in the regular educational stream throughout their high school years.

We recommend

that a variety of secondary school programs be developed in composite schools to meet the varying individual needs of students.

Vocational training programs Our Committee is convinced that attention should be given to the age of admission to vocational programs and to the question of the duration of courses. The responsibility of selecting students for work experience should be assumed by a Placement Officer, who, in cooperation with the principal, teachers and guidance staff, places the student in the area of work most suited to him.

We recommend

that the decision to place a child in a vocational class or school be made jointly by the school and the helping services in the

community and that admission rules be flexible enough to meet the requirements of individual students.

We recommend

that plans be developed to provide four and five year vocational programs that enable students to remain in school until the age of twenty-one if necessary.

We recommend

that a placement officer be assigned to work in close liaison with local industries and other employers in the community to ensure that vocational programs reflect the needs of the community and that students are placed in the area of work most suited to them.

Guidance counsellors Such matters as individual time-tables and flexible scheduling now put great demands on guidance and counselling services. Properly trained counsellors could perform an important preventive service within the schools.

We recommend

that training programs for guidance personnel be upgraded to equip counsellors to understand their role and to clarify when and which children should be referred to appropriate community agencies.

We recommend

that a goal be established to staff secondary schools according to the ratio of one guidance counsellor for every two hundred and fifty students.

Community-school approach Much of the 'acting-out' behavior that may appear to be emotional disturbance in school children is alleviated when a community-school program is developed.

We recommend

that boards of education give high priority to the development of community-school programs with particular emphasis placed on the need for such programs in inner city areas.

Liaison between the institutional school and the community school Liaison between the school serving the child while he is in a residential treatment setting and the school in the community to which he returns should be strengthened in order to help the child make a successful transfer back to his community school.

We recommend

that liaison be strengthened between the school serving the child while he is in a residential treatment setting and the school in the community to which he returns, to ensure that the home teacher will receive adequate information upon which to base a suitable on-going education program for that child.

As a principle we support the idea that children who are in residential treatment facilities, wherever possible and when it becomes appropriate, receive their education in the local public schools.

Another possibility would be to offer the therapeutic benefits of the classroom in the treatment centre to children in the community who have special needs.

We recommend

that staffs of boards of education and residential treatment facilities explore the possibility of effecting flexible arrangements that would enable children to attend school in the treatment setting or in the community on an interchangeable basis.

FOR CONSIDERATION OF PROVINCIAL AUTHORITIES

Community services

Neighborhood day care centres

Services supportive to families

The structure of Children's Aid Societies

Diagnostic and treatment facilities in the juvenile courts

Guardianship systems

Community planning at the regional level

Provincial and regional facilities

Further study

FOR CONSIDERATION OF PROVINCIAL AUTHORITIES

Community services Policy makers have a major responsibility for accelerating the pace of change to bring about a more cohesive system for provision of services. The definition of a 'community' and planning for personal care services is a complex task that should be promoted by the provincial government and determined locally in cooperation with appropriate departments of government.

We recommend

that all present services be advised by their central authorities of the adverse effects of the institutionalization of children and the fragmentation of services.

We recommend

that existing services be encouraged to engage immediately with their associates in a co-operative effort to reduce this trend.

We recommend

that a major portion of currently available service resources be made available to the community which should be responsible for its own needs and establishing new services to meet them.

Neighborhood day care centres Day care in a variety of forms has strong possibilities for prevention. It can add to the socialization of the child. It can introduce him to diverse groups. It can enrich his fund of knowledge and curiosity, and it complements and often supplements what the family can provide directly. In general, it can prepare the child both intellectually and socially for entrance to school.

We recommend

that the appropriate departments of the provincial government take responsibility for further encouraging the development of a range and variety of neighborhood day care centres in communities in Ontario with particular emphasis placed on provision of care for children whose parents are away from the home during the day and children who are mentally or physically handicapped.

Services supportive to families Help is often only available in crisis situations and present funding patterns tend to perpetuate this state of affairs. However, it is equally important to direct efforts and funds towards the maintenance of mental health.

We recommend

that appropriate departments of the provincial government direct their attention to the possibility of obtaining federal funds that could be utilized to develop community services such as family counselling, homemaker services, day care and day treatment programs.

The structure of Children's Aid Societies More adequate funding of Children's Aid Society services to provide early family-centred intervention would be beneficial to the child and his family. The present emphasis placed on substitute care in situations of neglect provides for intervention at a late stage when problems have become complex and acute.

The assignment of statutory responsibilities for the care and protection of children in the province to Children's Aid Societies has created some confusion as to which agency, Children's Aid Society or Department of Social and Family Services, may be held accountable for these tax-supported services.

We recommend

that recognition be given to the problems inherent in the present structure, organization and funding of Children's Aid Societies in relation to their assigned statutory responsibility for care and protection of children in the province.

We recommend

that appropriate action be taken to ensure the provision of services that place emphasis on early family centred intervention and other preventive measures.

Diagnostic and treatment facilities in the juvenile courts Our Committee was concerned about the general lack of diagnostic and treatment facilities in juvenile courts of the province.

We recommend

that suitable arrangements be effected for a combined community approach to the provision of diagnostic and treatment facilities to juvenile courts in Ontario.

Guardianship systems Communities in Ontario do not seem to have the tested experience or the appropriate resources to provide an adequate 'home base' for disturbed children whose capacity to relate within a family is impaired.

We recommend

that there be a re-examination of present guardianship systems with special reference to the effects of wardship on disturbed or demanding children.

Community planning at the regional level Our Committee was concerned about the absence of a sense of reaching out to community groups and are somewhat sceptical about the potential for bringing about local action 'from the top down', particularly as Regional Expert and Technical Committees have no control of budget and cannot make policy decisions.

We recommend

that the five departments of government responsible for the implementation of the White Paper*further explore ways in which local citizen groups and community agencies could be consulted and involved in developing a plan for expansion and utilization of children's services.

Provincial and regional facilities A rational plan for utilizing services at different levels will require further collaboration between the relevant departments concerned with services to children at the provincial level. It will also require recognition on the part of the community that it has a responsibility for the basic examinations - physical, psychiatric and psychological - before a child is referred to a regional centre.

We recommend

that regional facilities offering services to children re-define their functions in relation

* 'Services for Children with Mental & Emotional Disorders' tabled in the Ontario Legislature January 27, 1967

to services at the community level and that in this redefinition there be utilization of the existing mechanisms for collaboration between the several relevant departments concerned with services to children.

We recommend

that a primary role of regional facilities be to develop treatment plans for cases that present major management problems and to provide consultation and training for staff who carry responsibility for continuing treatment and implementation of this plan in the local community.

We recommend

that regional facilities be available for the residential and day care treatment of those children who are currently beyond the scope of the community with the objective of returning them to their community at the earliest possible time.

Further study We have looked at the separate funding arrangements which now exist for children in different government departments and concluded that these are unwieldy, antiquated, and do not work to the best interests of children. A look at alternative arrangements leads us to believe that this whole question of coordination and the role of government in providing or funding services is a study in itself.

We strongly urge that any effort to increase funds for programs for children with emotional and learning disorders be preceded by consideration of the basic problems reiterated throughout this document, and that solutions be sought in the development of a community-based design of services.

We recommend

that a Commission on Children and Youth be appointed by the Government of Ontario to study the recommendations contained in the Report of the Commission on Emotional & Learning Disorders in Children and explore and initiate appropriate action in the following areas:

the needs of children today with particular reference to the economic, social and psychological conditions which lead to situations resulting in childhood maladjustment and family breakdown;

the measures necessary to be taken to prevent child neglect and delinquency in children;

the disposition and treatment accorded to children who are adjudged to be emotionally disturbed, delinquent, neglected or dependent;

the statutes presently existing in Ontario relating to such children;

the methods by which the efforts both of public and private agencies can be coordinated to achieve an effective service to children in need.

We recommend

that the Commission report be directed to the Premier of Ontario.

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